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AUTHOR Stroul, Beth A.; And Others
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ABSTRACT

The case studies contained in this document were developed as part of a national project to identify communities that have made substantial progress toward developing comprehensive, coordinated, community-based systems of care for children and adolescents with serious emotional disturbances and their families. After initial identification, communities were further selected for site visits based on such criteria as providing a range of services, having interagency coordinating mechanisms in place, utilizing a child-centered and family-centered approach, and incorporating a community-based system of care. The service delivery systems described in this document are located in four communities: Northumberland County, Pennsylvania; Richland County, Ohio; Stark County, Ohio; and Ventura County, California. Each case study includes an introduction to the project as a whole and a profile of the service delivery system, including the community context, the background and history of the system of care development, philosophy and goals, target population, system organization, system care components, system-level coordination mechanisms, client-level coordination mechanisms, system of care activities, system financing, evaluation, major strengths and challenges, and technical assistance resources. Following the case studies, a paper by Judith W. Katz-Leavy and others, titled "Individualized Services in a System of Care," reviews philosophy, process, operationalization, and evaluation of individualized services and includes implementation examples. The final section of the document provides brief summary profiles of 11 additional community care systems. (DB)

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PROFILES OF LOCAL SYSTEMS OF CARE

*for Children and Adolescents
with Severe Emotional Disturbances*



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CASSP Technical Assistance Center
Center for Child Health and Mental Health Policy
Georgetown University Child Development Center

July 1992

PROFILES OF LOCAL SYSTEMS OF CARE

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Prepared By:

**Beth A. Stroul, M.Ed., Sybil K. Goldman, M.S.W.,
Ira S. Lourie, M.D., Judith W. Katz-Leavy, M.Ed.,
and Chris Zeigler-Dendy, M.S.**

CASSP Technical Assistance Center
Center for Child Health and Mental Health Policy
Georgetown University Child Development Center

Funded by the National Institute of Mental Health
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These case studies on local systems of care for children and adolescents with serious emotional disturbances and their families would not have been possible without the support, cooperation, and input of many individuals. The authors wish to thank all those who assisted in identifying the communities to be included in this study. Their suggestions and perspectives were extremely valuable.

The authors also wish to express their sincere gratitude to the communities included in these profiles. Appreciation is due first for their vision, dedication, and commitment to improving services to troubled youth and their families and, secondly, for their contribution to the development of these case studies describing their systems of care. Community leaders, agency administrators, program staff, parents, youngsters, and advocates all were extraordinarily generous with their time both by telephone and on site. They arranged site visits affording the project team the maximum opportunity to learn about and observe their systems of care. They provided rich information and insight about their experience in developing systems of care and were candid about the struggles and problems they have encountered. Across the sites, there was genuine interest in "telling their stories" to assist other communities in designing and implementing systems of care. When drafts of the case studies were completed, key individuals from each site provided extensive review and feedback. Their cooperation in meeting extremely tight deadlines was most appreciated.

The opportunity to visit and to become acquainted with individuals from each of these communities proved inspirational for the project team. The authors hope that the profiles will serve as an inspiration and guide to other communities to develop local systems of care for youngsters and families.

Beth A. Stroul, M.Ed.
Sybil K. Goldman, M.S.W.
Ira S. Lourie, M.D.
Judith Katz-Leavy, M.Ed.
Chris Zeigler-Dendy, M.S.

Profiles of Local Systems of Care

for Children and Adolescents with Severe Emotional Disturbances

NORTHUMBERLAND COUNTY, PENNSYLVANIA

**Prepared By:
Ira S. Lourie, M.D.**

**CASSP Technical Assistance Center
Center for Child Health & Mental Health Policy**

**Georgetown University Child Development Center
Funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)**

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INTRODUCTION

This case study was developed through a project conducted by the Child and Adolescent Service System Program (CASSP) Technical Assistance Center at Georgetown University. It is part of a descriptive study of local systems of care which was initiated in 1990 and funded by the National Institute of Mental Health (NIMH), Child and Adolescent Service System Program. The project has involved identifying and studying communities which have made substantial progress toward developing comprehensive, coordinated, community-based systems of care for children and adolescents who are severely emotionally disturbed and their families. Individual case studies of each local system of care are the products of this effort and are intended as technical assistance resources.

Systems of care for troubled children and adolescents have been of great interest over the last several years. In 1982, Knitzer estimated in her seminal study, Unclaimed Children, that of the three million children with serious emotional disturbances, two-thirds were receiving no treatment whatsoever and countless others were receiving inappropriately restrictive care because of the lack of community-based service alternatives. In 1986, Saxe conducted a study for the Office of Technology Assessment of the United States Congress which confirmed Knitzer's findings and stated that "Mental health problems are a source of suffering for children, difficulties for their families, and great loss for society. Though such problems are sometimes tragic, an even greater tragedy may be that we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available."

In response to these problems and to the growing number of calls for change, the National Institute of Mental Health launched the Child and Adolescent Service System Program (CASSP) in 1984 to assist states and communities in developing community-based systems of care for this underserved population. Through grants and technical assistance activities, CASSP has supported the development of interagency efforts to improve the services provided to the most troubled children and youth and their families. To provide a conceptual framework for system of care development, CASSP supported the publishing of A System of Care for Severely Emotionally Disturbed Children & Youth by Stroul and Friedman in 1986. This monograph has been called a blueprint for action in the child mental health field, and it describes the various service options required by these youngsters and the need for services across all of the relevant child-serving agencies. From these components, Stroul and Friedman proposed a design for a "system of care" encompassing both the full range of services and the mechanisms required for the assurance of their appropriate delivery. Currently, there is widespread agreement that community-based systems of care for youngsters who are severely emotionally disturbed and their families are needed, and the development of these systems has become a national goal.

Despite the calls for such systems of care, until recently there were few, if any, examples of local systems of care which combined an array of community-based services with other essential elements including interagency collaboration and case management. Today, there is what might be described as an explosion of activity related to system of care development. The activities of CASSP, which have now involved every state, have played a crucial role in stimulating system development at state and local levels. Increased attention to children's

mental health by advocacy groups also has had a major impact. Further, system building has been advanced significantly by initiatives such as the Robert Wood Johnson Foundation's Mental Health Services Program for Youth, which has provided funds for the development of systems of care in selected local areas, and extensive system development initiatives in a number of states. As a result, many communities now have evolving systems of care which can be studied and described. Descriptions of the system building approach and experience of these communities are designed to assist other communities which are attempting to develop such systems.

Potential sites for inclusion in this study were identified through a process of consultation with key informants including individuals at national and state levels who have extensive knowledge of developments in the children's mental health field and in the development of local systems of care in particular. Through these initial discussions, approximately 20 communities were identified. These localities were characterized as having made significant progress toward the development of community-based systems of care consistent with the philosophy and principles which have been promoted by CASSP and which are displayed on the following page. Accordingly, an attempt was made to locate local systems which are family focused, emphasize treatment in the least restrictive environment, involve multiple agencies, individualize services, and so forth. Similarly, an attempt was made to locate systems which have moved beyond the more traditional outpatient, inpatient, and residential treatment services and have begun to develop a more complete and balanced array of nonresidential and residential services including home-based services, day treatment, crisis services, therapeutic foster care, respite care, case management and others.

The second phase of the selection process involved extensive telephone interviews with a representative from each site to obtain detailed information about the array of services available in the community, the nature and functioning of the system level coordination mechanisms, and the nature and functioning of the client level coordination or case management mechanisms. In addition, information was collected about any special system activities related to such issues as financing the system, evaluating the system, involving families in planning and delivering services, and enhancing the cultural competence of the system of care. A chart was prepared for each potential site summarizing the service array, system level coordination mechanisms, and client level coordination mechanisms.

Selection of sites for further study was accomplished with the assistance of an advisory committee and was based on the following set of criteria:

1. Must have a range of services in place (home-based services, crisis services, therapeutic foster care, and others).
2. Must have interagency coordination mechanisms in place.
3. Must have client level coordination mechanisms in place, e.g., case management.
4. Must be a sufficiently well-developed local system to be able to serve as a useful example to the field and to receive national attention.

CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.
5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.
6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
10. Emotionally disturbed children should receive culturally competent services which are sensitive and responsive to cultural differences and special needs and are provided without regard to race, religion, national origin, sex, physical disability, or other characteristics.

5. Should have some noteworthy activities in one or more areas including family involvement, cultural competence, transition, high-risk children and adolescents, financing, and evaluation.

An initial group of five communities was selected for site visits by the project team. The site visits generally involved spending three to four days in each community engaged in a variety of activities designed to provide insight into the functioning of the system of care. These activities included interviews with a number of individuals and groups including key system managers, senior management representatives of the major child-serving agencies (mental health, child welfare, education, and juvenile justice), case managers, youngsters, parents, and advocates. Additionally, the schedules included visits to three or more service components in the system of care where activities were observed and discussions held with program managers, staff, and, in some cases, clients. An important aspect of the site visits was observing the functioning of interagency entities. Site visitors attended meetings of interagency entities focusing on system-level coordination as well as meetings of interagency teams organized for the purpose of creating individualized service plans for specific youngsters and their families. The site visits provided a wealth of information about each system of care -- its developmental milestones, strengths, and obstacles yet to be overcome.

The sample of communities studied yield valuable insights into the process of building systems of care. Due to an enormous increase in system development activities in communities across the nation, there currently are many more noteworthy examples of local systems of care. It should be emphasized that none of the communities selected for study have fully developed systems of care, and all are struggling to overcome financial and other obstacles to system development. Rather, they are communities which have succeeded in putting some basic building blocks into place and have demonstrated progress toward achieving system development goals. The resulting case studies are intended to serve as technical assistance resources for other states and communities as they approach the challenge of developing local systems of care for youngsters with severe emotional disturbances and their families.

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PROFILE OF A SYSTEM OF CARE: NORTHUMBERLAND COUNTY, PA

I. COMMUNITY CONTEXT

Northumberland County is located among hills and valleys in central Pennsylvania, bordered on its western side by the Susquehanna River and on the east by the Pennsylvania coal fields. It is about 60 miles due north of Harrisburg, the state capital. The area has four distinct seasons with cold snowy winters and pleasant summers. As of 1991, its makeup is 51 percent rural and 49 percent urban (primarily small towns) with three major population centers spread across the county's 453.4 square miles.

Northumberland County has a population of 96,771 with 22,450 children under the age of 18. Of the three small cities in the county, Sunbury, with a population of about 12,000, is the largest and is the county seat, and the major industry is government. Because it has the largest part of the population and is central to most of the rest of the county, it serves as the focal point for most services. Shamokin has a population of almost 11,000 and, lying in the eastern part of the county, is the county's center for anthracite coal industry activities. Milton has a population of about 7,000 and, lying in the northern part of the county along Interstate 80, acts as a center for a major trucking firm. The small towns near Shamokin are also "coal towns," while the rest of the small towns in the county are farming communities.

Northumberland County has its employment concentrated in industry, small farm agriculture, and coal mining. Both the farming and mining segments of the county's economy have been depressed for over 15 years. This is especially true in the coal regions which have suffered from the decline in the use of coal and from the coal fires that burn under part of the county. As a result, poverty has been a major problem in the county. The median income is near \$11,000, placing it among the poorest 10 percent of the counties in the state, with 11 to 12 percent of the population living below the poverty line. There is great disparity of income levels within the county with the average income in one region being twice that in another. "Unearned" income (welfare benefits and Social Security) has grown at a rate nearly five times that of business and industry.

A recent development has been the consolidation of pockets of poverty within the county. Many of the upper middle class families from the three small cities are moving to suburban and rural areas of this county and surrounding counties. This type of population migratory pattern is reflective of larger urban areas and is leaving behind a concentration of poverty in the more urban communities. Both in the anthracite coal and farming regions of the county, several communities have become pockets of poverty as a result of economic depression in these industries. This consolidation of poor families has been accentuated by the availability of rapidly deteriorating inexpensive housing which is available in some communities and draws impoverished families from other areas.

Another significant demographic trend in the county has been the out-migration of individuals in the 20-50 age bracket due to economic and employment conditions and an in-migration of the elderly. This has created a population shift toward the elderly, lower-class

families, and children with a resultant reduction in the county's tax base and an increase in the demand for social services.

The minority population of the county has historically been less than one percent. There has been a significant shift during the last five years, however, with the minority population having doubled and continuing to show an annual increase. The majority of this increase is the result of in-migration of Hispanic families from the metropolitan New York area. There has been an 81 percent increase in minority population in the last decade. As of 1990, minorities had increased to 1.3 percent of the total population. With its history of predominance of individuals from ethnocentric European cultures, the county has not been prepared for working with minority populations, and services have been slow to adjust.

As of 1990, approximately 2,295 children were being served at any given time by the human service system, including children who were receiving special education services for emotional disorders. Over the last several years, Northumberland County has had one of the highest rates of reported child abuse referrals and of substantiated child abuse cases in the State of Pennsylvania. In addition, Northumberland County has experienced a significant increase in the number of sexual abuse referrals.

While there is a great need for human services throughout the county, services tend to be located in one of the major population areas creating a particular challenge to accessibility since there is no county-wide transportation system. This presents a significant hardship and barrier to children and families who live in outlying areas of the county. Small satellite service centers in outlying locations have not proven to be useful for those families with the greatest problems, particularly for children and adolescents with severe emotional disturbances.

The human service system in the Commonwealth of Pennsylvania consists of several large agencies including: the Department of Public Welfare, which houses mental health programs, the Department of Education, the Department of Health, which houses drug and alcohol programs, and the Juvenile Court Judges Commission. These agencies have major mandated state funding streams from which they create specific programs under state regulations. However, much of the state funding of localities in Pennsylvania is through block grants which go to counties; local service systems are controlled by County Commissioners and local boards of education except for special education which is a state-level function administered regionally through Intermediate Units.

The following child-serving agencies and systems provide services in Northumberland County and are key players in the system of care:

- o Northumberland County Department of Human Services: a unified agency that serves the following functions: mental health, child welfare, juvenile probation, drug and alcohol, and mental retardation.
- o Education: Boards of Education in nine school districts; and special education services administered regionally through the Central Susquehanna Intermediate Unit.

II. BACKGROUND AND HISTORY OF SYSTEM OF CARE DEVELOPMENT

History of the System of Care

Systems change is a relatively new concept to Northumberland County. Prior to 1980 there had been few, if any, attempts to modify the way the system operated to deliver services. The 1960s saw the advent of the community mental health movement out of which a local mental health capacity was created, using a federal community mental health center grant. However, there was little capacity for meeting the mental health needs of children nor those individuals served by other community agencies.

In the early 1980s, a systematic approach to human services in Northumberland County did not exist. Each of the agencies provided services within its own context and felt that it was a struggle to obtain services from other agencies to meet the full range of client needs. The juvenile probation agency dealt with this situation by creating its own continuum of care including outpatient counseling services and a specialized education program called Coordinated Learning Alternatives for Northumberland County Youth (CLANCY). Similarly, the child welfare agency contemplated the development of its own outpatient service capacity and was using mostly private sector services and placements.

The mental health agency offered few mental health services for children and was seen by the other agencies as unresponsive and unavailable. Until the mid-1970s, community mental health services were provided by a community mental health center (CMHC) at the Geisinger Hospital which is in an adjacent county. This CMHC served two catchment areas, one being Northumberland County and the other being an area comprised of the surrounding four counties. The reasoning behind this ungainly catchment area structure was related to the relative poverty of Northumberland County when compared to its neighbors; it also reflected traditional struggles among the counties involved.

Around 1975, Geisinger Hospital, deciding that the CMHC program was becoming less profitable, closed that program's doors. This left each catchment area in the position of having to create its own new public mental health capacity. Northumberland County responded by developing mental health services to be delivered by the county's Department of Mental Health.

What the Department of Mental Health developed was a traditional mental health clinic with an office-based service model that tended see "patients" who came on a voluntary basis. Emotional problems typically were treated with therapy, out of the context of the rest of the individual's problems. This philosophy was seen as "elitist" by the workers in other agencies who complained that the mental health workers "didn't want to listen" to what they had to say about families, offered no follow-up to referring agencies, and closed cases when reluctant referrals failed to appear for therapy. In addition, there was a very low level of child mental health expertise available within this mental health unit. In fact, in 1980 the County Mental Health Department had been ranked last in the state in quality of service delivery and in compliance with state regulations. As a result, the other public agencies were at a loss for responsive, qualified public child mental health resources and felt obliged to buy such care from private sector providers available in the community.

In Pennsylvania, each county creates a Board of Commissioners which is elected by its local citizens; these county commissioners are vested with the power to determine the structure of their human service delivery system. Northumberland County's Board of Commissioners had heard agency complaints and was not pleased with the way services were being delivered. Commissioners had knowledge about children who were "falling through the cracks" and felt that the categorical structure of their human services would not allow the closing of gaps in the system. This understanding was aided by the experience of several commissioners in the mental health field. One commissioner had been a member of the original Governor's Advisory Panel for implementing the Mental Health Act in the 1960s; two other commissioners had served on the original county mental health/mental retardation advisory board in the early 1970s. From this background, there was a strong representation on the Board of Commissioners for mental health issues and support for systems change. This situation was very different from similar small counties where county commissioners were known to have "gotten in the way" of systems change.

Although it appears as if the commissioners would not have changed the system on their own, their growing frustration with the failure of categorical programs to solve the human service problems of the county, led them to create a climate which was conducive to change. Change began in 1984 when the state threatened the county with loss of licensure and state funding unless changes were made in its mental health and mental retardation programs (MH/MR). The commissioners responded to this failure of MH/MR management by changing the agency director. They made a politically brave move by asking the director of the county Juvenile Court Services Agency to take over MH/MR. Even though this individual had formal mental health training, he had worked in juvenile justice for the last 13 years. He was well known for his innovative management of the Juvenile Court Services Agency and his development of in-house mental health services. Significantly this director insisted that he would take over the MH/MR agency only if he were allowed to also remain as Director of Juvenile Court Services.

The selection of the new director was based on the commissioners' recognition that system leadership had grown out of the juvenile services agency over the years since 1979. The CLANCY program had been started in that system well before the need for system of care was conceptualized. However, the CLANCY program embodied the belief that systems must respond to the changing needs of youth. This "alternative service" concept became the driving philosophy of the Juvenile Court Services Agency in the county. It was the Juvenile Court Services Agency that provided leadership in developing the new system of care and unified agency approach, and it is this same spirit that has driven the entire system of care to be responsive to the needs of individual children and families.

Combining the two agencies under one director served to assure that the mental health capacity within MH/MR would be structured so that it could meet the needs of the Juvenile Court Services agency. Having seen the creative approaches to using mental health resources in juvenile probation, the director of child welfare was desirous of setting up outpatient mental health capacity within the child welfare agency, just as Juvenile Court Services had done. However, it was felt that in order to offer outpatient services, Medicaid reimbursement was needed. When a request for Medicaid reimbursement was rejected by the state, the child welfare agency sought help from the new Director of MH/MR. In response, the director encouraged the child welfare agency to join in a partnership to create a mental health service

capacity that could meet the full needs of child welfare clients. This partnership involved using the newly created capacity within the mental health agency to serve child welfare clients and included a proviso that no outside mental health service would be purchased unless it was clear that the mental health agency could not meet that need. This agreement initiated a process of looking within the agency to receive necessary services and put the onus on the agency to develop services geared to meet identified needs in the community.

At the time of the merger of MH/MR and Juvenile Court Services in 1984, all of the agencies were ready to begin working more closely together. The vehicle for increased collaboration was the creation that year of an entity called the Children's Clinic. The Children's Clinic, described in greater detail in a subsequent section, was developed as a coordinating mechanism for children with mental health needs. It has subsequently evolved into a case management system and further serves as a gateway for all mental health services (not just for those children and adolescents with severe emotional disturbances). Rather than being a program for serving children and families, the Children's Clinic acts as a process for assuring adequate and appropriate cross-agency interventions. The Children's Clinic initially was slow in developing at first, with individuals and agencies feeling their way along. As this process proceeded, it allowed agencies with less overt investment to feel comfortable joining in without being threatened.

In 1985, Pennsylvania received a Child and Adolescent Service System Program (CASSP) grant from the National Institute of Mental Health. Through this federal grant, the state aimed to improve the provision of services to children and adolescents with severe emotional disturbances through the development of county-wide inter-agency mechanisms for service coordination. Northumberland County was in the first group of five counties to receive a local CASSP grant through this state program. The timing of the CASSP grant was perfect for the enhancement of the county process of system integration. When presented with the state request for proposals for CASSP, the county officials who had been involved in the development of the Children's Clinic saw it as an unexpected outside reaffirmation of their program integration principles. With this outside support from the state, the Children's Clinic process was empowered by CASSP to grow and solidify as the accepted local practice. The CASSP Coordinator, hired under the grant, became the convener of the Children's Clinic. In this role, the coordinator encouraged the development of the process by centralizing staff development and bringing people together.

Following from the interagency concepts of the Children's Clinic and CASSP, in 1987 a unified human service agency was created which combined the child welfare, mental health, substance abuse, and juvenile probation agencies under the leadership of the individual who had been the Director of Mental Health and Juvenile Court Services. All of the agency components were moved into the same building. The creation of this unified human service agency was not the result of a state-driven initiative, but rather it was the result of an evolution in service delivery within Northumberland County. The reorganization was possible since county governments in Pennsylvania have the power to structure local agency components in any way they want, as long as needed services are provided and state mandates fulfilled. This flexibility allowed the county to create a unique structure that met its current needs.

This unified agency has directed the development of a continuum of services to meet the various needs of children, adolescents, and their families. Each service component participates as part of an integrated system. System components range from a reconstructed program of outpatient individual and family psychotherapy, through therapeutic foster care to respite care, shelter care, home-based family preservation and crisis intervention services, day treatment services, social skills programs, juvenile probation services and parenting programs. There are no formal residential or hospitalization programs directly related to the system, and the use of such resources is rare and seen as extraordinary.

In addition, the system of care does not have a cut-off which separates the delivery of services for children and adolescents with severe emotional disturbances from children with lesser needs. As a result, all children with a perceived mental health service need are seen through the Children's Clinic process, each getting the degree of attention and intensity of treatment necessary. Further, there are no formal case management systems in mental health; the Children's Clinic provides a case management function which is supplemented by selected agency personnel on an as-needed basis.

State Influences on System of Care Development

Prior to 1984, the Commonwealth of Pennsylvania had made significant progress toward the creation of an improved service system for children and adolescents with severe emotional disturbances. Since 1980, the Pennsylvania Office of Mental Health has placed high priority on the need to improve the child and adolescent mental health service system in its annual state mental health plan. This plan was based on the concepts of a comprehensive community mental health system following from deinstitutionalization. Each county is required to prepare a county mental health plan that is consistent with the priorities that are elucidated in the state plan.

In addition, the state had another methodology for insuring the growth of child and adolescent mental health services at the county level. This process was centered around the allocation of funds to counties to be used exclusively for the expansion of outpatient and partial hospitalization programs for children and adolescents. Further, in 1982 the state created a children's Community Residential Rehabilitation Services program which provided highly structured living arrangements in either group or host home settings with maximum supervision, personal assistance, and a full range of psychosocial rehabilitative services.

The State Office of Mental Health also encouraged interagency coordination of services. This occurred within the juvenile justice agency by the creation of the capacity to provide mental health services for youth incarcerated in juvenile justice institutions and forestry camps throughout the state. Also funded were a number of demonstrations of local interagency programs that involved the provision of mental health services to the population of other agencies including child welfare, health, mental retardation, and special education. Along with these demonstrations, the Office of Mental Health developed a cooperative interagency agreement with the Office of Children, Youth and Families, the state child welfare agency. This agreement promoted the development of similar interagency agreements between local MH/MR and child welfare units.

Following from this strong start, in 1984 the State Office of Mental Health in the Department of Welfare applied for a federal CASSP grant in the first year of that national program. It was awarded a grant from the first CASSP review; funding began in early 1985. This CASSP grant built on the county structure of the state service delivery system, and from it was developed a two-tier system development strategy. At the state level, a CASSP Committee comprised of system participants, advocates, and parents was created. This committee assumed the role of defining a state-level philosophy for the delivery of services for children and adolescents with severe emotional problems and their families. Further, the committee created a process for the development of systems of care at the local level throughout the state.

Most innovative in Pennsylvania's CASSP effort was the focus on local system-building from the earliest time in the grant. This local focus acknowledged the power vested in counties and the importance of making an initial major impact at the local level. Pennsylvania's plan involved creating a CASSP committee, similar to the state-level CASSP Committee, in each county. This was to be done in stages, using the federal CASSP dollars to give counties small state CASSP grants. In the first year of Pennsylvania's CASSP grant, five counties were given local CASSP grants -- one of these counties being Northumberland. Since that time, local system development has been mandated by the State Office of Mental Health, and state dollars have replaced the federal in the funding of county projects throughout the state.

Northumberland County was struggling with creating a unified service system that provided better access to mental health services. It was almost simultaneous with the creation of the Children's Clinic that the state began offering local-level CASSP grants. Northumberland County was appreciative of the state and local CASSP initiatives in that they reaffirmed the count's emphasis on interagency coordination and provided a mandate from above to continue in the direction that had already been established. Additionally, the local CASSP grant offered the county the resources with which to hire a CASSP Coordinator, the individual who became the "glue" that held the county's new system together.

Another way that the state influenced and supported the development of local systems of care was by providing technical assistance. Through the federal CASSP grant, the state hired several individuals whose roles were, in part, to work with the local grantees. These individuals helped local communities to understand the state-level CASSP philosophy and how to translate these ideas to meet local needs and political realities. Each year, the state has held conferences for local service deliverers, advocates, and family members to further develop the concepts of the system of care as applied to Pennsylvania counties. Participation in these conferences has been very helpful to the counties, including Northumberland, in creating a spirit and a camaraderie that drives systems change across the state.

The state has also influenced local service development through state funding of local service components. In 1987, the state received funds from the legislature to develop and provide local Family-Based Mental Health Services. Northumberland County used this initiative to develop the Homekeepers Program which provides intensive home-based services for children and adolescents with severe emotional disturbances and their families.

Another state initiative that has had a major impact both within the state and in Northumberland County has been the Student Assistance Program (SAP) which is a joint

initiative among the state mental health, drug abuse, and education agencies for the prevention of adolescent suicide. SAP programs, modeled after Employee Assistance Programs, are school-based efforts to work through a consortium of community agencies to reach children and adolescents who are at risk for a number of problems including emotional and drug abuse problems. The joint education/mental health/drug abuse funding of these projects across the state has had the effect of further emphasizing the interagency nature of the state's commitment to systems change and offers a model by which localities can move toward more responsive integrated, systems of services for children and youth. Northumberland County has SAP programs in each of the county's high schools and several junior high schools. Participation in the SAP program by these school districts has had a major impact on enhancing the participation of the schools in other system improvement efforts such as the Children's Clinic.

One of Pennsylvania's priorities has been to encourage parent participation in the development of the state and local service systems and to emphasize parents as providers of service for their children and adolescents. Through the Parents In Need (PIN) program, the state used its CASSP grant to fund the training of parents and the development of local parent groups across the state. While the development of parent programs has been slow in Northumberland County, the state influence has been supportive of the county's own emphasis on the role of parents in the development of the system of care and of individual treatment plans and its focus on family-based services.

Individuals who have been involved in the development of the Northumberland County system of care are convinced that without the positive state influence, critical changes would not have taken place, or at the very least, would have taken much more time and effort. The relationship between the state and the county in changing systems is an important two-directional process. The county is presently waiting for the state to change some of the rules related to service delivery and financing which would further encourage and facilitate interagency unified service concepts at the local level. Most importantly, the county system would prefer fewer restrictions on the length of time youngsters can be placed in foster care without having to be committed to county care. This would allow placement with greater family involvement and would avoid forcing families to give up custody of their children in order to get appropriate services. Further, the county would like the state to change some rules related to financing of services to enable the county to use funds more flexibly to enhance its ability to blend funds in order to create a pool of undesignated funds to be used as appropriate for individual service plans.

III. PHILOSOPHY AND GOALS

The mission statement of the Northumberland County Department of Human Services is stated as follows:

"Our mission is to improve the quality of life within the community by:

- o Empowering the residents of Northumberland County to achieve their highest level of functioning and independence;

- o Promoting mutual respect, rapport, and partnership with the community . . . families, residents, and staff;
- o Protecting and serving Northumberland County's most vulnerable citizens; and
- o Advocating the values of family life and the dignity of each family member; while
- o Enhancing, developing, and effectively managing our resources".

This mission statement reflects several major tenets of the Northumberland County system's philosophy:

- o **Quality Circle** - A major aspect of Northumberland County's philosophy is the concept of the "Quality Circle," a Japanese form of management which includes a process whereby all participants have a role in the ongoing development of the agency's philosophy and practices. The concept of the Quality Circle reflects the desire by the department administration to make decisions only with a broad base of input from service delivery participants ranging from clients to front line workers to administrators. The process of the Quality Circle allows all participants to feel that they are part of the decision making process; it insures that each has ownership of the decisions and the resultant system development.
- o **Consumer Focus** - Inherent in the mission as stated is the understanding that the agency is there to serve. "The people we serve are the primary focus of our programs." Listening to the "customer" is important. In fact, the philosophy states that the "customers" include families, other agencies, and the community. Additionally, while the Quality Circle includes agency administrators and customers, it also includes front-line workers who, along with families, are felt to have the best perspective on service needs. When a system is built upon a consumer-driven policy, the child and family become the center of service delivery rather than the agency itself. Thus, the agency is there to do whatever is necessary to provide appropriate services.
- o **Family Focus** - Families are seen as the most important resource for children and adolescents. The intervention modalities used in the county are oriented toward the family rather than toward the individual child. Services are delivered to the family as a whole to the extent possible, and, when that is not possible, inclusion of the family remains a primary intervention goal. Similarly, keeping children in their homes is seen as most appropriate, and, when that is not possible, reunification of the family remains a primary goal. Intensive services are delivered in a home-based manner whenever possible, because it is felt that home-based services are more effective and that this approach solidifies the commitment to the family. To insure that families feel that they are considered as full participants, they are always included in case planning as a part of the treatment team. The staff philosophy is that services should be aimed at maximizing the potential of families to care for and raise their children. For families that have difficulty participating in the intervention process, the department has created the Parent Center, which works with parents who

wish to enhance their parenting skills and their ability to support their children. In addition, a new foster care pilot effort allows foster parents of children removed from their homes to work with the natural parents. Further, families are included in the planning for future program development.

IV. TARGET POPULATION

The target population as identified by the Northumberland County Department of Human Services includes children who are processed through their multidisciplinary service planning process called the Children's Clinic. This group represents, for the most part, those children who are involved with multiple systems and are in need of mental health services.

From a practical point of view, the target population of the Northumberland County Department of Human Services includes all children who have needs that are to be addressed by the public sector. From the standpoint of mental health, the target population is comprised of all children and adolescents who require services from the mental health component of the agency including, but not limited to, children and adolescents with severe emotional disturbances and their families.

The broadness of this definition of the target population reflects the philosophy of the system which involves approaching each child and family from the context of their unique needs. The system is created so that each child and family can receive the amount or intensity of service that they need from each of the agencies. Children and adolescents with severe emotional disturbances, those at risk for that serious disturbances, and those who have less serious mental health needs all can be served by the system and its coordination mechanisms. Because a child does not need to have a particular level of mental health or multisystem need in order to be eligible for the full range of services and coordination, there is little concern about excluding children and families or of their "falling through the cracks."

Further, the system recognizes that the service needs of children and families are not as categorical as the programs designed to provide for them. The definition used in the county for the system of care target population tends to foster the concept of declassification of services by not requiring that the child be categorized before he or she receives services at any level. While the mandates of various components of the agency, such as protective services and juvenile services, force some categorization, the system definitions help minimize the effects of the categorization and aid the system in looking at the full range of needs.

The target population includes children who come through each of the system components: mental health, child welfare, mental retardation, juvenile justice, drug and alcohol, and education. In the 1990-91 fiscal year, the Children's Clinic saw 375 children and adolescents, which represented 1.5 percent of all children in the county and 20 percent of those served in the agency as a whole. The ages ranged from birth to 18 with 62 percent being 12-18, 25 percent being 6-11, and 13 percent being 5 and under. The minority population served was only about two percent of the minority population of the county, which is small to begin with -- about 1.3 percent of the total county population.

Children and adolescents seen in the Children's Clinic during this period had a wide range of primary diagnoses:

	Percent
Autism/Developmental Disorders	7
Major Depression/Bipolar Disorder	8
Tourette's Syndrome	4
Eating Disorder	7
Anxiety Disorders	10
Attention Deficit Disorders	10
Post Traumatic Stress	7
Alcohol-Related Problems	4
Conduct/Oppositional Disorders	2
Adjustment Disorders	32
Miscellaneous	9
 Total	 100

Of note is the high percentage of serious psychiatric disorders represented in this population -- over 20 percent. Only 32 percent were diagnosed as being in the often over-used adjustment disorder category, and only two percent were seen as having a conduct or oppositional disorder, in spite of the fact that many of these children came from juvenile justice services. Given the serious level of most of the diagnoses, the Children's Clinic appears to be serving a population of children and adolescents with severe emotional disturbances.

V. ORGANIZATION OF THE SYSTEM

System Management

The Northumberland County system of care has been created and is run as a function of the Northumberland County Department of Human Services. The department resulted from the unification the major human service components under one agency. It is this unified agency that drives the system of care in the county; the department serves as the administrative and fiscal agent for all of the various programs under its auspices.

The unified nature of the system makes it impossible to separate out the services for children and adolescents with severe emotional problems from the care of other children and adolescents. Even the Children's Clinic, which coordinates the clinical function of the system, is not focused solely on those with the greatest need. Rather, the focus is on all children and adolescents with any need. The Children's Clinic coordinates support for any family with a child who has any level of mental health or multiservice need.

Power is vested in the director of the department, but is redistributed to the agency as a whole through a Human Services Management Team. This team consists of the directors of major component agencies and programs in the department who meet regularly and are

vested as a group with the responsibility for making policy decisions for the department. The department also espouses the philosophy of the Quality Circle, a form of participatory management in which all employees of the department have a say in the management of the department and in the development of policy and programs. Because of this management policy and the fact that the agency is small, there is a unanimity of thought that drives the system. The director reports to the County Commissioners on all of the programs in the department and also reports to the President Judge for the juvenile justice programs. Agency components within the department have program directors who report to the director of the department.

This unified human service agency has the power and capacity to directly provide or to purchase most of the services that children and their families need, with the exception of those provided by schools. There is also a great deal of flexibility in the handling of most of the funds that come to the county from the state or which are generated at the county level. Although some funding streams are dedicated to very specific populations, the department has the capacity to direct many funding streams into jointly supported programs, thus approximating joint or blended funding.

Role of Participating Agencies

- o Mental Health: Mental Health/Mental Retardation (MH/MR) Services and the Northumberland County Counseling Service (NCCS) of the Department of Human Services

The MH/MR Program of the department serves as the primary intake and assessment vehicle for all mental health services for adults and children. Within the system of care, the MH/MR Program is the entry point for all youngsters felt to be in need of mental health services. This intake and assessment as well as emergency services, are provided in what is called the Base Service Unit (BSU). There are two locations for the BSU, one at the main office in Sunbury on the western side of the county and another in a satellite center in Shamokin, on the eastern side. The BSU also is responsible for case management functions. While the BSU has relatively few resources allocated specifically for children and adolescents (two case managers), the role of the BSU is amplified by its close relationship the Children's Clinic, which is the departmental-level case coordination and planning mechanism for young people with multiagency need. The close integrative nature across the department offers the BSU the support it needs to perform its function in spite of its sparse resources.

The Northumberland County Counseling Service (NCCS) is a separate mental health program within the department. It provides two basic system service components: outpatient counseling and intensive home-based services for children and adolescents with mental health problems (known as Homekeepers). Services offered by these two components act as the major mental health resources in the county system and are available only through referral from the Children's Clinic. Mental health services are provided with the family being the focus of treatment. Most of the services are family-oriented, clinic-based outpatient or intensive in-home interventions. When this is not possible, individual treatments are offered which have family unification as a treatment goal to the extent possible. These are well-staffed services and are well-

integrated into the other services of the department. The Homekeepers program has staff funded by both child welfare and juvenile justice budgets.

o Child Welfare: Children and Youth Services of the Department of Human Services

Children and Youth Services (C&Y) is the child welfare agency within the department. As such, it serves the traditional functions of child protection, foster care, and adoption as well as the newer functions of family preservation and therapeutic foster care. Each of these services is accompanied by case management provided by the appropriate program. As a member of the Children's Clinic, C&Y activities become part of the unified system of care. Because there are important state mandates for most of the services offered, C&Y can never feel completely free to give up its program boundaries within the system of care. This becomes most evident with: 1) the commitment requirements of foster care, and, 2) the requirement that family preservation programs serve **only** newly referred child protection clients. Many of the youngsters and their families served by C&Y also have mental health needs and can access services from NCCS through the Children's Clinic.

The foster care programs, both regular and therapeutic, are essential services in the system. They are used to serve multiple purposes including shelter, crisis stabilization, respite, and therapeutic placement as well as traditional longer-term alternative family placement. Regardless of state regulations, flexibility created within the Northumberland County system has allowed these resources to be used to freely meet the specific needs of children and families. The basic problem in the use of foster care by the system is that after 30 days of voluntary placement, the child's custody must be given to the department. While this rule is more flexible than child welfare policies in many states, it still puts a strain on the system. Participants in the service system, including those from C&Y, feel that this custody issue is a major obstacle in the full unification of the system.

o Juvenile Justice: Juvenile Court Services Program and CLANCY/Special Services Program, of the Department of Human Services

The Juvenile Court Services Program is the juvenile justice component of the system. This program offers juvenile intake, probation, and guidance services. For youth with more severe problems, this program also offers intensive probation and intensive drug and alcohol probation. While each child served by these programs must come through the police or the district magistrate, the programs are integrated with other departmental efforts. Many of the adolescents involved are in need of, and are provided, mental health services available through NCCS or support/residential services available through C&Y. The Children's Clinic is the gateway through which these other services are accessed by youth involved with the juvenile court.

CLANCY (Coordinated Learning Alternatives for Northumberland County Youth)/Special Services Program is a collection of services that offer alternatives to more traditional interventions for youth. These include social rehabilitation, day treatment, outward bound, and camp programs. Within the system of care, CLANCY serves a very special purpose. By institutionalizing these alternative approaches, the

department has demonstrated its commitment to programming that meets individual needs. Further, since CLANCY developed as a juvenile justice program, its presence in the service system demonstrates the links between juvenile justice and the other program areas. CLANCY youth can access mental health services from NCCS and Homekeepers through the Children's Clinic, and, conversely, youth in other program areas can be referred to CLANCY through the Children's Clinic.

- o Education: Seven Local School Districts Serving Only the County and Two Districts Shared with Other Counties, Plus the Central Susquehanna Intermediate Unit

Regular class schools are operated by seven school districts exclusively serving the county and two districts shared with other counties. However, special education services are offered directly, as well as supported in local schools, by a regional Intermediate Unit operated by the state. The Central Susquehanna Intermediate Unit is the special education collective that serves the region in which Northumberland County lies. It offers a wide range of special education services for children and adolescents with severe emotional disturbances, and it works with the various school districts in mainstreaming efforts.

While these school-based special education programs have not directly integrated with the human service agency in the past, they are becoming more cooperative and are being seen as part of the total system. There also is more direct service integration with the local schools. This is especially true with the Student Assistance Program (SAP), a school-based prevention and early intervention program for children and youth with drug and alcohol problems or at-risk for suicide which is jointly funded by the state-level education, drug and alcohol, and mental health programs. The Department of Human Services provides a liaison to each SAP team who attends at least 50 percent of its staffings. The Human Services Department also provides training and technical assistance for all SAP and related school staff who are interested and funds a full-time school liaison position to coordinate these activities. Each school district in the county has a relationship with the Children's Clinic. While various districts have developed better relationships than others with the system of care, each sends representatives to meet with the Clinic concerning individual children.

- o Substance Abuse: Drug and Alcohol Program (D&A) of the Department of Human Services

There is a strong understanding that children and youth with emotional problems and their families often have concurrent drug and alcohol-related problems that require special intervention. These programs are represented in the Children's Clinic. D&A staff perform substance abuse assessments, offer some educational groups and outpatient therapy, and make referrals to private providers. These programs are closely related to the CLANCY programs as well as to the Student Assistance Programs run by the schools. The substance abuse programs offered by private providers include a group for children of alcoholics and 47 prevention groups in elementary schools.

- o Health: Pennsylvania Department of Health

Public health services, while available to a small degree through a State Health Department clinic in an adjacent county, are not an integral part of the system of care for children and adolescents with emotional problems. This gap in the system of care is partially addressed through the county's new priority on early intervention in response to P.L. 99-457. Additionally, a Local Interagency Coordinating Council (LICC) has been created and to improve early intervention services.

- o Mental Retardation: Mental Health/Mental Retardation Program (MH/MR) of the Northumberland County Department of Human Services

Services for persons with mental retardation are included in the same administrative unit, the Base Service Unit, as mental health services. Representatives of retardation services are not regular members of the Children's Clinic. However, when appropriate, those families with dual mental health/mental retardation needs come to the Children's Clinic for the development of full service plans.

VI. SYSTEM OF CARE COMPONENTS

As noted, the Northumberland County Department of Human Services has four major sub-agencies: Mental Health/Mental Retardation, Children and Youth Services, Drug and Alcohol Service, and Juvenile Court Services. Each of these service components has its own service mandates and its own intake and assessment process. Each service component offers a range of services, some of which are offered only to mandated populations and some of which are more generally available to all clients of the overall agency. It is a difficult task to describe the structure of the Department of Human Services for actual service delivery in no way approximates the flat structure as drawn on an organizational chart. Rather, services are offered in a hub-type structure in which services respond to the needs of individual families; each coordinating with others and reporting to the Children's Clinic as an integrating body and to the department director.

The continuum of services offered by the department includes the following:

- o **Intake/Case Management/Case Work** - Provided through the Mental Health and Mental Retardation agency's Base Service Unit (BSU), through the Children and Youth Services' Child Protective Services and General Protective Services programs, and through the Juvenile Court Services' Juvenile Probation program
- o **Intensive Case Management** - Provided through the Children and Youth Services agency
- o **Substance Abuse Services** - Provided through the Drug and Alcohol Services agency and the Student Assistance Program (SAP) within the school districts

- o **Youth Services** - Provided through the Juvenile Court Services' Coordinated Learning Alternatives for Northumberland County Youth (CLANCY) program within the Special Services division.
- o **Parent Support** - Provided through the Parent Center
- o **Outpatient Family Therapy** - Provided through the Northumberland County Counseling Services' Outpatient Services and Homekeepers programs
- o **Day Treatment** - Provided through CLANCY's, the Geisinger Hospital's, and the Central Susquehanna Special Education Intermediate Unit's day treatment programs
- o **Home-Based Services** - Provided through Children and Youth Services' Family Preservation program and through the Mental Health Services' Homekeepers program
- o **Foster Care and Therapeutic Foster Care** - Provided through the Children and Youth Services' Regular Foster Care and Therapeutic Foster Care programs
- o **Independent Living Services** - Provided through Children and Youth Services
- o **Hospitalization and Residential Treatment** - Provided through outside resources

Intake/Case Management/Case Work

In Northumberland County's system of care the traditional outpatient function is not the least intensive mental health intervention offered. Intervention is felt to begin at intake, and the intake worker has the capacity to offer a basic level of case management with a therapeutic function that is recognized by the system as being a mental health intervention. Some of these intake/case management services take place under the mental health component of the agency, while others are offered by workers in the child welfare and juvenile services components.

Entry into the mental health component of the Department of Human Services occurs in two ways. All clients new to the Department enter the system through the intake function of an entity called the Base Service Unit (BSU). Most emergencies also are handled by this unit. Clients who are involved with Children and Youth Services or Juvenile Court Services gain access to mental health services through the Children's Clinic function without going through the Base Service Unit.

The BSU serves both children and adults and has several major functions, all of which are provided by caseworkers called case managers. While there is no formal breakdown between adult and children's services in the BSU, there are two case managers who do almost all of the child and adolescent work (one in the main office and one in the satellite office). The case managers assigned to children are responsible for all individuals from birth to age 18, or up to 21 if the child is still in school. The case management function of the BSU includes a basic level of case management services (including intake, assessment, counseling and referral) and a second level involving intensive case management. The basic case management function is seen as one that assures that people get the services that they need. While this includes

primarily referral and coordination, some clients receive counseling delivered directly by the case manager. Intensive case management is for those individuals and families who have more significant problems.

The first function of the BSU is intake and assessment. Self-referred individuals and families are seen first by a BSU worker. This worker handles an initial assessment and carries out required administrative activities. The assessment focuses on the seriousness of the problem and the immediate degree of need. Identified needs can range from the need for psychiatric evaluation, to immediate counseling intervention, to being seen at a later time when an appointment is available.

At times, intake and assessment are triggered by a mental health emergency. For emergencies, the BSU has individuals who act as crisis workers. In most instances, a children's case manager handles day time emergencies for children and adolescents. After hours, this function is served by whomever is on call. Consultation is available to both the children's case managers and the adult crisis workers from the staff of the Homekeepers Program (intensive home-based mental health services) or through psychiatric consultants of the department. An intervention option available during emergencies is the commitment of individuals, under State Statute 302, to a hospital for assessment and psychiatric care. Case managers and crisis workers are encouraged to use both Homekeepers and psychiatric consultation in these decisions, with every possible resource being used before a child or adolescent is actually hospitalized.

The BSU case manager has several options for working with any given case. The first of these is to keep the case as a counseling client for as long as necessary. This case disposition is based on the ability of the case worker to deliver the degree of therapy needed and the lack of need for more intensive or multiservice interventions. The length of this intervention can range from several weeks to several years, although cases kept at this level usually have shorter-term needs. Individuals and families who need only counseling or psychotherapeutic services may be referred out of the department to private or not-for-profit counseling services. The ultimate disposition will be determined by the ability of the family to pay for services and the availability of appropriate community resources.

Some children and families are found to have complicated psychiatric needs. These families are immediately brought by the case manager to the Homekeepers staff or to the agency's psychiatric consultants for evaluation. Most of these cases are ultimately referred to the Northumberland County Counseling Services (NCCS) and to Homekeepers through the Children's Clinic, although few are kept in the BSU for service, with psychiatric support from department consultants.

Families who are not kept at the basic case management level or referred out to community resources are referred to the Children's Clinic for multiservice coordination or more intensive mental health therapeutic services within the department. From the Children's Clinic, children and their families are guided to the type of intensive mental health or multiservice package that their needs dictate. One option is referral back to the Intensive Case Management Program in Children and Youth Services as part of the service plan.

Case managers have case loads that number over 100 clients. While this may seem like an extremely large case load, most of these cases require only maintenance. The current policy states that every individual or family receiving mental health services will be assigned to a case manager. However, most of these cases are receiving primary services elsewhere in the agency, and the case management role is to follow up and assure that services are being delivered as planned. The case load for which the case manager has primarily responsibility is relatively small, typically under 20. The children's case managers also are responsible for sitting on the Children's Clinic and for working with the school Student Assistance Programs. Case managers are required to have the minimum of a bachelor's degree with a human service emphasis; a small percentage have master's degrees in social work or counseling.

Intake into the child welfare programs of the agency is primarily done through child protection programs. As with mental health, there is a counseling function that is provided by case workers in the protection programs. If youngsters seen in these programs need more intensive mental health interventions, they have access to these through the Children's Clinic.

The Children and Youth Services agency has two levels of protection programs: Child Protective Services and General Protective Services. In general, the Child Protective Services program is for those cases in which the county is mandated to investigate and intervene. Child Protective Services is responsible for conducting an initial intake in all protective referrals. Cases which are felt to be within the agency's mandate are served by Child Protective Services; others are referred to General Protective Services. Each of these components is based on traditional social service models. When case workers feel that children and/or families have mental health needs beyond their ability to provide for, they access mental health services through the Children's Clinic. There are two child protection workers who focus on sexual abuse and three who focus on physical abuse; each has a caseload of 8 to 12 families. There are 12 general protection workers, with caseloads of 27 families.

The intake/case management function for the juvenile justice component is called Juvenile Probation. Before the agency was unified in 1984, the Juvenile Court Services agency was the trendsetter in offering a full range of services. It had developed a continuum of care to meet the needs of children and families referred by the police and the juvenile court. As a result, its program of case management is the model used as the basis for designing services provided by the other units, in particular mental health. This model consists of a basic level of juvenile probation services, a more concentrated level of intensive probation, and, finally, a full range of mental health and support services provided through the Children's Clinic. An important function of Juvenile Probation Services is that it is the first line of drug and alcohol assessments for children and adolescents, some of whom are referred for more intensive drug and alcohol services or for intensive drug and alcohol probation.

Juvenile Probation offers counseling and case management services for youth who have committed offenses and are referred by the police. This program acts as an arm of the juvenile court as well as being part of the Human Service Department's system of care. The primary service is case management and basic-level counseling by the juvenile probation worker. If this is not sufficient, there are more intensive options available including diversion programs, foster care, and intensive probation. Two intensive probation programs

are offered. One, called Intensive Juvenile Probation, is for youth who are violent and have a high risk of placement. The other, called Intensive Drug and Alcohol Probation, is for youth involved with drugs and alcohol (funded under a special state grant, Pennfree). There are six juvenile probation workers, one for Intensive Juvenile Probation, and one for Intensive Drug and Alcohol Probation. Most of these workers have degrees in criminal justice at the bachelor's or master's level. Regular probation workers have caseloads of between 30 to 60, while intensive probation workers have caseloads no greater than 15.

For more intensive mental health services, youth and their families are referred to the Children's Clinic, where they can access the entire continuum of care of the department including specialized programs for sex offenders and substance abusers. Juvenile Probation appears to use the Children's Clinic less than other agency components, perhaps because it has a wide range of options available within its own program including foster care homes, forestry camps, and secure residential treatment programs. The program also has direct access to the Special Services/CLANCY programs and does take advantage of the Homekeepers Program and the Community Residential Rehabilitation programs, all described below.

Intensive Case Management

Intensive case management is a function that C&Y provides for those clients and their families who are found to be in need of a service that provides them ongoing service coordination at all times. While this function can generally be provided by the Children's Clinic itself, sometimes the service needs of a particular child and family are so complex that an intensive case manager must be assigned to assume responsibility for assuring that all service components are working together. In other cases, the family may require the specialized support of an intensive case manager to assure that it is able to make adequate use of the services provided.

The Intensive Case Management Program has three staff who work with families three to five times a week. These families typically are served for approximately six months. Intensive Case Managers have specialized training and are usually chosen from case managers with extensive experience. As noted, Juvenile Court Services also offers intensive case management services.

Substance Abuse Services

Alcohol and drug programs are provided to children and adolescents who are found during assessments to be in need of higher-level drug and alcohol treatment. These services are mostly performed by private contract providers in the community. There is some outpatient intervention, primarily through groups. Rarely, an adolescent is referred for inpatient drug or alcohol treatment which is available in Philadelphia, 140 miles away.

The Student Assistance Program (SAP) is a prevention program that is based in the public schools and provides early intervention with children and youth who have drug and alcohol problems and who are at risk for suicide. Developed through a state initiative modeled after employee assistance programs, and jointly funded by the state Department of Education and the Drug and Alcohol and Mental Health Programs of the state Department of Human

Resources, each high school and junior high school in the county offers this program. For elementary school age children there is a new, similar state program which currently is in place in three county schools with plans to cover the entire county by 1995. SAP provides counselors who are available in schools for children and adolescents to access on their own and by referral from school staff. Through a process of assessment (including specific drug and alcohol assessment), individual intervention, and groups in some sites, youth are urged to explore the degree and depth of their problems in a confidential, nonjudgmental setting that is readily available to them. Particularly, but not exclusively, aimed at substance abuse and suicide prevention, this program is able to identify at-risk youth and refer them for more intensive help when necessary. The Children's Clinic is most often used to access these services. During 1990, 99 youth were served by SAP, 45 of whom were referred to the Children's Clinic. SAP staff also are used for liaison with other child-serving agencies in the county and for training.

Youth Services

The Department of Human Services has a division called Special Services which falls under the Juvenile Court Services component. The basic program offered by the Special Services division is Coordinated Learning Alternatives for Northumberland County Youth, or CLANCY. Several important services are added to the system of care through the youth services provided by CLANCY: life skills/GED, social rehabilitation, job training, day treatment, and summer day camp.

The Life Skills/GED program works with a broad range of youth who are both self-referred and referred through other parts of the agency. Focusing on educational equivalency, this program helps young people who are not doing well in school or in the community to perform better in a range of life skills. A youth can walk in off the street and start to receive services from this program without a referral from other agency components; this is the only CLANCY program where self-referral is allowable.

The Social Rehabilitation program is for youth ages 10 to 18 and focuses on their ability to adequately live in their families and in the community. The program aims to increase the social and practical skills needed to progress through adolescence. The program offers structure and respite during nontraditional hours for children and youth who are "not making it." The rationale for the program is that traditional therapeutic mechanisms have not had an impact on this particular youth population and that another approach is required. The program operates after school four days a week and on Saturdays. Included in the services offered are homework assistance/tutoring, community service/helping activities (such as a recycling program), recreational activities, and group therapy. For youth who have greater needs, other services can be accessed through the Children's Clinic, including outpatient therapy and family preservation activities. Seventy youth currently are served in this program which is funded through mental health dollars. The cost runs a little over \$700 per youth annually.

The Job Training program is for older youth and is funded from a state Job Training Partnership Act (JTPA) grant. It includes preemployment and life skills training as well as education, social case work, counseling, and job coaching. Some of the youth have ultimately transferred into technical school programs. Most of the youth involved in the program have

problems with delinquency or are found to be at-risk. This programs costs a little over \$600 a year per youth.

The Day Treatment program in CLANCY is the newest youth program and aims to be a community alternative to juvenile justice institutionalization. Almost all of the youth are ordered by the court to attend, but some are placed by school districts as alternative education. The program has similar components to the social rehabilitation program, with a greater emphasis on drug and alcohol treatment. The program meets five days a week and has an educational component supplied by the Special Education Intermediate Unit. An important part of this program is a "mini" Outward Bound-type component, in which there are four one-week outings each year with five weekend follow-ups. In this way, the concepts of self-reliance and competence that are the basis of Outward Bound and Forestry Camp programs are integrated into a community-based, noninstitutional program. The program is funded by a state juvenile justice grant and serves about 30 youth at an annual cost of approximately \$50, 000, of which \$18,000 supports the Outward Bound component.

CLANCY also runs a therapeutic summer camp for at-risk children and youth from ages eight to 14. The camp serves appropriate children and youth from the other CLANCY programs as well as all of the children in the camp's age group who are in the Community Residential Rehabilitation (CRR) therapeutic foster care program. The camp program also has many of the components of the social rehabilitation program. In addition, there are camps for younger children run by Children and Youth Services. The cost for the 170 children and youth served is \$38,000 which is provided by a state child welfare grant.

Parent Support

Parent support is offered through the Parent Center, one of the newest of Northumberland County's services. Started in 1989, it aims to support the needs of parents, particularly those parents who have lost custody of their children to child welfare or are at-risk for such loss. The types of problems addressed by the Parent Center include functional illiteracy, poverty, trouble with day-to-day parenting skills, and drug and alcohol abuse. Families are referred from any component of the agency, but most referrals come from child welfare. The program was originally funded by a grant from the Governor's Drug Council; it currently is supported by joint funding from the Children and Youth, Mental Health, and Drug and Alcohol agencies. The program currently operates in two sites at opposite ends of the county and serves 55 families a week at a total cost of \$100,000 a year.

The Parent Center program is run by parents who have received assistance from the department in the past. They describe themselves as "parents helping parents." Family members referred to and participating in the program are encouraged to see the staff as other parents who are "friends." Staff see their role as being parent advocates or "parents who have had problems and have gotten help."

The main program meets daily from 11:00 a.m. to 2:00 p.m. These hours meet the needs of most clients, many of whom are single parents and/or unemployed. Van service is provided as a form of outreach for parents who are unable to find other transportation. Day care is an essential aspect of this program. The basic program includes therapy and substance abuse groups, parenting skills training, substance abuse education, and social skills training.

These activities take place through informal gatherings and craft sessions. The schedule remains the same each day, with a mixer to start, then an education session, followed by a therapy or substance abuse group, and finishing with crafts. Lunch is part of the program. Each family is assessed by the program staff and is given the special service components of the program that it requires including a literacy program and an employment training program. The Parent Center also operates evening groups which target housing projects and other sites throughout the county.

Outpatient Services

In 1989, the outpatient psychotherapy function was brought together into a new entity called the Northumberland County Counseling Services (NCCS) which is located within the Mental Health/Mental Retardation agency. NCCS has two major components: Outpatient Services and Homekeepers (which is an intensive home-based intervention).

NCCS operates outpatient services based on the principle that psychotherapy serves a focused, time-limited function. NCCS believes that the supportive functions often associated with psychotherapy can be provided elsewhere, usually through a case manager. Within this framework, psychotherapy is always seen as one part of a more complete service plan. This perspective prevents therapy from becoming an isolated service, and, in turn, prevents therapy from being seen as the primary intervention modality in complex situations in which multiple services are required.

Another way of looking at the role of psychotherapy in the Northumberland County system is to say that a basic level of therapy, or counseling, is provided by workers throughout the service components. It is only when more specialized services are needed that formal psychotherapy is offered through NCCS. This philosophy forces the psychotherapists to see themselves as part of team in which they have a particular role; the job which the team must perform requires more than the psychotherapist can offer alone. This frees up the psychotherapist to do internal consultation needed by the system as well as the necessary therapy. With the recognition that they are part of a team, the psychotherapists must come to understand the team function and, in turn, the other team members become more comfortable in accepting them. Ultimately, the family benefits since psychotherapy is delivered in a manner that is relevant to a treatment plan and is coordinated with other services that the family receives.

NCCS offers primarily structural family therapy in its outpatient services. This choice of theoretical base is derived from an understanding of the family needs of the population served by the human service agency as well as an institutional affinity for family therapy as a primary modality. Some group therapy is available as well as individual therapy individual therapy opportunities, including play therapy, for those youngsters in need of psychotherapy whose families will not become involved. However, in these instances one of the therapeutic goals of the Family Service Plan is the further participation by the family in therapy.

The treatment philosophy calls for brief, problem-focused interventions, and the length of treatment is dictated by the complexity and seriousness of the problem. Since psychotherapy usually is not offered as a solitary service, psychotherapeutic interventions focused on specific

problems can be terminated when those problems are ameliorated; ongoing support functions can then be fulfilled by more appropriate service system components.

Most families that are referred for treatment in NCCS fall into several categories: one group which requires three to four sessions; a group with more entrenched problems which receives 10 to 12 sessions; and a group with more complex and multiple problems which receives treatment for six months to one year. Families that have shorter treatment courses are invited for further therapy if the need arises; the supportive nature of the entire system allows for this in-and-out therapy without fear of "losing" the family in between. Most families are seen weekly for the first four sessions. Many of these families show some positive movement during this period and are then seen every other week until the treatment is terminated. Other families demonstrate a greater therapeutic need and treatment schedules are adjusted to meet these needs.

NCCS Outpatient Services are operated in a way that makes them as accessible as possible. This service is open to families of children from birth to age 21. As often as possible, children and families are seen together. There are no waiting lists, as the service operates on the premise that emergencies cannot wait and that these are usually among the most productive times for intervention. Since referrals only come through the Children's Clinic, NCCS is part of the referral process and can work with the Clinic team to assess therapy needs and the degree of immediacy of those needs. As part of the team, NCCS then has a stake in making sure that appropriate services are available. In addition, NCCS offers consultations to case workers/case managers and provides family therapy training to the entire agency staff.

Therapy is offered when the families are available, and evening hours are part of the ongoing schedule of services. Most families seen in NCCS are Medicaid-eligible. Those that are not, either pay the Medicaid rate or are subsidized by generic mental health funds that support the agency. The agency purchases some outpatient services from the community, either from group practices or from nonprofit agencies. These providers must be willing to invest in the service system in order to get the business. This investment includes participating in coordination activities and training. However, given the problems of public-private agency interaction, cases seen by outside providers tend to be those that require less coordination.

A clinical director for the mental health structure has a master's in counseling with special training and certification in family therapy. There are six therapists, half of whom have master's degrees in social work or in psychology; all have had training or experience in family therapy.

Day Treatment

The CLANCY day treatment program described above under Youth Services, is one of three day treatment alternatives available in the county. A new Day Treatment Program has recently been opened at the Geisinger Hospital. The program, which had not yet opened at the time of the site visit, is aimed at providing post-hospitalization or preventive treatment to youth with psychiatric diagnoses. This program meets five days a week after school and includes psychotherapy (individual and group) as well as a program of social skills and rehabilitation. While it appears to be very similar to the CLANCY program, it is geared more specifically toward working with youth who have psychiatric needs.

The Central Susquehanna Special Education Intermediate Unit offers day treatment in the form of day school programs for children and youth who are seriously emotionally disturbed as defined by PL 94-142. There are three such programs located in various schools in the county and shared by all of the local school districts. Children and youth who are enrolled in these programs can access other services through the Children's Clinic. In addition, several of the local school districts have alternative school programs for youth who require an alternative educational approach.

Home-Based Services

The next more intensive level of care in child welfare beyond protective case work is the Family Preservation Program. This program is aimed at newly discovered cases in which there is a high risk of removing the child from the home. The goal of this program is to provide the home-based services that will allow the child to remain in the home. It is based on the Homebuilders model, but is extended to provide services for a three-month duration. The Family Preservation Program has been designed to provide crisis intervention for families that are new to the social service system and offers support and a basic level of case management, but no formal therapy. The needs of these clients are assumed to be less than those served by the Homekeepers program, which is reserved for families who have not responded to less intensive services or are returning to the system repeatedly. The Family Preservation program has four workers who have caseloads of five families each.

A separate program under NCCS is the Homekeepers Program, which provides intensive home-based services for families with emotionally disturbed children and adolescents. Started in 1988, Homekeepers is aimed at the most troubled individuals for whom less intensive interventions have not been successful and institutionalization is imminent. The program offers long-term services, ranging from six months to one year. Although the Homekeepers program is under Mental Health, several of its staff are supported by Children and Youth Services.

Criteria for admission to the Homekeepers Program are informal and include multiproblem families being seen on an outpatient basis and/or families with children who are at risk for out-of-home placement. The program also works toward the reintegration of families where children have been placed outside of their homes, some for several years. Many of the children seen with their families in the Homekeepers Program are considered to be seriously emotionally disturbed or mentally ill. For cases referred by the Children's Clinic, there is a no-reject policy. Most families are referred from the Children's Clinic, though some may be referred directly from institutions, including hospitals. On an emergency basis, direct referrals will be accepted from other agencies. In addition, Homekeepers staff is called upon to provide consultation, directly or through the Children's Clinic, regarding the need for home-based services. Each staff member serves as a liaison with specific programs and agencies.

The Homekeepers Program has five professionals who work as a team serving about 30 families at any one time. Other team members are available for support and to cover when the primary worker is unavailable. The family receives the amount of worker contact in the home that the situation requires, averaging between one-half to six hours per week, depending upon the needs of the family. When referrals are first accepted, the family is

most often in what is called the "crisis phase" which calls for an extremely intensive intervention, often several hours a day. During this time the family works closely with the team to bring the family crisis under control. Beyond the usual supportive and therapeutic interventions that are available in home-based intervention, the team also utilizes consultation and supports from other services in the system of care which can be accessed through the Children's Clinic when necessary. As the crisis is resolved, the care then enters a "stabilization phase" in which the intervention decreases in intensity. During this phase, the family is supported in making changes that may prevent further crises. In about two-thirds of the cases, the family receives a referral to other system components for ongoing care and support. In the other one-third, the Homekeepers intervention is sufficient, and further referrals are not necessary.

When respite becomes necessary for the youth and the family during the crisis or stabilization phase, temporary placement is made by purchasing foster care from the child welfare programs in the department. While these placements are not made into the host homes used for therapeutic foster care, the foster parents used are experienced in working with troubled children and adolescents. These placements are reviewed after five days and can be made for up to 30 days without formal commitment to the Children and Youth Services agency.

The cost of an average episode of care in Homekeepers is about \$8,500, based on a cost of \$72 per hour at an average of three hours a week for nine months. This cost is currently covered by a grant from the State Office of Mental Health under an Intensive Family Based Service Grant program. The state is in the process of revising its Medicaid plan to allow Homekeepers to be a Medicaid-billable program.

Foster Care and Therapeutic Foster Care

Foster care is seen as the primary out-of-home placement in Northumberland County. This is due in part to the lack of formal group homes or shelters. There are two levels of foster care offered by the Children and Youth Services agency: Regular Foster Care and Community Residential Rehabilitation which is therapeutic foster care.

In many respects, the regular foster care offered in Northumberland County is structured much like other traditional foster care programs. However, the prevailing philosophy of the agency is that children and adolescents belong at home and that foster care represents a failure of the system to resolve the problem in the home. Regular foster care serves a number of different purposes. The first of these relates to child welfare issues concerning the inability of the family to ensure a child's safety in the home and the judgement by the agency that the child must be removed, at least temporarily. Initially, this is seen as a crisis intervention, with the hope that the child can be returned home as soon as possible.

Secondly, regular foster care serves as the first level of residential services in most cases that have a mental health need. Even when a child meets the criteria for the therapeutic foster home program, placement most often is in a regular foster home either on a crisis or on a longer-term basis. As long as the child can be kept in a regular foster home, that is the placement of choice, regardless of the mental health problem. It is only if the needs of child are not being met in the regular foster home that a therapeutic home is considered. This

blending of regular and therapeutic foster care functions is seen as an important part of the service continuum, allowing as much flexibility as possible. Many of the therapeutic foster homes also have regular foster care children at the same time.

Thirdly, when a child has a placement need related to a delinquency problem, the foster care program is the first choice. While the juvenile probation workers may feel that specialized foster care would be useful for their population, it is felt that the needs of the children in the Juvenile Court Services agency are similar to other populations of troubled children and that the same foster care resources are sufficient. Currently, Juvenile Court Services pays for five of the county's foster care homes. Fourthly, regular foster care is seen as having a crisis intervention function. This resource is used to offer children and/or their families respite on a short-term basis until a crisis can be resolved. Children can be placed voluntarily for up to 30 days in foster care under Pennsylvania rules.

Family participation is a new facet of the foster care program. On a pilot basis, several foster parents have been asked to work with and act as ongoing resources for some of the families of the youngsters in their homes. The idea for this service extension came from the positive experience with the Parent Center which was designed to work with parents who needed therapeutic, social skills, and educational support in order to keep their children at home. Recognizing the gains made by families with this type of support, it followed that similar support could be offered to the parents of children in foster care by some of the more sophisticated foster parents.

Started in 1986, Community Residential Rehabilitation (CRR) is the therapeutic foster care program used by all components of the system. Known also as the "Host Home" program, it was created to increase the system's capacity to keep children and adolescents with severe emotional disturbances both within the county and integrated as much as possible with their families. CRR originally was supported by a state child welfare grant; the funding for most of the cost of this program currently comes from Title IVE funds. CRR is a program jointly administered in the county by mental health and child welfare. The homes and foster care workers are provided by child welfare and the program coordinator is provided by mental health. Of the \$24.50 a day paid to therapeutic foster parents, \$20.50 is provided by Children and Youth and \$4.00 by Mental Health.

The formal criteria for referral to the CRR are that the child must be under 18 years of age and unemancipated, must have a mental health diagnosis, and must "have exhibited maladaptive interpersonal behavior over a period of time, which significantly impairs the child's functioning within the family and peer groups." What this means practically is that the child is a threat to self or others, has been or is at imminent risk of hospitalization or other residential placement, or has been moved several times between foster care homes for mental health reasons. In practice, most children, even those who meet the official criteria for CRR, are initially placed in a regular foster care home. Since the CRR staff are available to support regular foster care parents with almost the same intensity of support provided to therapeutic home parents, youngsters who meet the criteria for referral to CRR often can be maintained in regular foster homes. Only if the placement in the regular foster home does not work is the youth then placed in the Host Home. Throughout the entire process, the same CRR staff works with the child. Being in CRR assures that there will be a "meaningful response" by the staff whenever necessary; "[the case coordinator] is always there!" Most of

the foster families prefer to take both regular and CRR children, so the transition between regular and therapeutic foster care often is an administrative matter which results in the home getting more support services.

Parents for CRR are recruited from the pool of regular foster parents. They are selected on the basis of their history of dedication and a willingness to accept the principle of "no reject, no eject" for the CRR children. They receive specialized training of about one month's duration. Training is adjusted based upon the level of sophistication and experience of the parents. It is expected that someone always be at home in Host Homes. The daily rate for CRR is \$24.50 a day, in contrast to the \$16.50 a day paid for regular foster care. The average length of stay is one year, with a range of six months to four years.

All referrals for CRR must come through the Children's Clinic. As a result, all CRR placements are reflections of Family Service Plans. All children placed out-of-home also have a Residential Service Plan which expands the Family Service Plan to cite the reasons for placement, the expectations of the child and family in placement, and the plan for reunification. Each child has a CRR case manager who has a maximum case load of eight. CRR case managers have a minimum of a bachelor's degree.

Independent Living Services

The Children and Youth Service agency has a small independent living program for late adolescents who cannot live in a home, but are not ready for emancipation. This program offers housing supported by Title IV-E and a state grant. The youth in this program are supported by a case manager who, through the Children's Clinic, has the ability to obtain other services that the adolescents may need. These most often are mental health, special education, or job training services which can be accessed through NCCS, the Intermediate Unit, and the CLANCY program.

Hospitalization and Residential Treatment

Northumberland County has no residential facilities for children and youth; it has neither group homes nor residential treatment centers. Because the continuum of care requires out-of-county placement if these type of services are needed, the department has developed alternatives in the county. Because these alternatives have been so successful, there has been little need for the development of other residential services. The residential function is primarily served by foster care and therapeutic foster care services; these services are also used for shelter, respite, and longer-term out-of-home care. While Juvenile Services sometimes uses state-run forestry camps and, occasionally, a state-run secure residential facility, most placements are in county foster care and therapeutic foster care homes.

The Geisinger Hospital, which had served as the local community mental health center in the past, now offers inpatient hospitalization as well as day treatment services to the county. Geisinger Hospital is available to provide acute care to adolescents, who are admitted to adult units. The hospital is also involved in the system of care by providing psychiatric consultants through a contractual arrangement.

The nearest state hospital, which is also the nearest facility for children under the age of 12, is 60 miles away. In response to this problem, the system of care has created sufficient supports so that hospitalization is almost never required. No child under 12 has been hospitalized with county dollars for over three years, and the number of adolescent admissions has been reduced by more than half. Still, the lack of community-based hospitalization options for the under-12 population is seen as a gap in the system, and the department is working to remedy this situation.

VII. SYSTEM LEVEL COORDINATION MECHANISMS

When the Children's Clinic was started in 1984 and the unified Department of Human Services was formed several years later, there was virtually no interagency collaboration in Northumberland County. The county has used these two events to create a context for agencies to work together. Several mechanisms have been used to enhance interagency collaboration at the system level: the Human Services Management Team, the Quality Circle, and the CASSP Team.

Human Services Management Team

The Human Services Management Team consists of the directors of the various component agencies of the Department of Human Services as well as the heads of several key programs. This team includes the directors of Mental Health/Mental Retardation Services, Northumberland County Counseling Services, Children and Youth Services, Juvenile Court Services, and Special Services. The director of the department has vested in this group the power to make policy and program decisions across the agency. The philosophy that drives the team is that decisions are made jointly, reflecting the needs of all the component agencies and ensuring coordination and cooperation among all participants. Through this team there is a blurring of component agency boundaries. As a result, problems are seen as "our" problems. The team has learned that in order to meet the cross-agency needs of the children and families they serve, categorical boundaries must be eliminated and children and families must be viewed individually. Despite the fact that many categorical boundaries still exist, the team has found creative ways to design joint programs with shared funding and/or staffing to fulfill their shared mission.

Quality Circle

The power of the Human Services Management Team is enhanced by the concept of the Quality Circle that has become an integral part of the management of the department. As noted, this is a Japanese business management technique in which workers at all levels are included in the assessment of a business and its management, leading to inclusion in ultimate changes in program and policy. At the Northumberland County Department of Human Services, the Quality Circle is an annual exercise. Input from line workers, mid-level managers, and executives decreases the possibility of top-down decision making that does not reflect the realities of practice and of the community. The Quality Circle offers valuable feedback to the Human Services Management Team on how its decisions have impacted the

workers and the families served by the agency. Further, it offers the team insight from the service delivery level on program gaps, coordination difficulties, and management problems.

Through the Quality Circle process, staff at all levels in the department gain ownership of the agency. This makes them partners and helps them to feel as if they count. They are able to see that their clinical and personal experiences can, and are, translated into program changes and into new programs. The agency as a whole has used this annual renewal to reaffirm its commitment to the children, families, and community it serves.

Child and Adolescent Service System Program (CASSP) Team

The major cross-agency coordinating mechanism in the county, extending beyond the department, is the CASSP Team. Northumberland County was one of the first five Pennsylvania counties to receive a CASSP grant as part of a state initiative to better serve this target population. While both the federal and state mandates for CASSP focus on the population of the most disturbed and disabled children and youth, Northumberland County has used its CASSP process to develop its entire system to serve not only the CASSP target population but also other children and families in the service system.

The CASSP Team provides Northumberland County with a forum for discussing system development, its progress, and its functioning. This then leads to planning for further systems development. This process is facilitated by quarterly meetings of the CASSP Team which includes: the CASSP Coordinator; the director of the Northumberland County Department of Human Services; the directors of Children and Youth, Mental Health/Mental Retardation Programs, Northumberland County Counseling Services, Drug and Alcohol Services, Juvenile Court Services, Special Services, the Parent Center, and the Central Susquehanna Intermediate Unit; representatives from the Alliance for the Mentally Ill of the Central Susquehanna Valley; and foster parents. At these meetings, the current functioning of county-wide programs is reviewed, and system needs are discussed. One of the uses of this county-wide, interagency process is to measure the progress of the county in reaching both state and local goals and priorities for system development.

A major effect of the CASSP Team and process has been the formalization of the system of care philosophy throughout the county. Each of the entities participating on the CASSP Team feels ownership of the system changes being implemented, thus avoiding the concern of agencies that system change is being imposed on them by others. When there are struggles across agencies about new system structures or policies, the CASSP Team becomes a forum for the resolution of these problems. In this regard, the CASSP Team and process is described as the "flag waver for systems change," and the "keeper of the philosophy or values." The CASSP Team and the CASSP Coordinator are intimately intertwined with all of the county's system change initiatives and play a major role in the convening and coordination of the Children's Clinic.

Joint Services

One of the mechanisms through which services have been coordinated has been joint work between programs within the department and across other community agencies. This has taken place using several models including joint funding, joint administration, and joint

staffing. Each strategy ensures that: 1) services are delivered in the least categorical manner; 2) services needed by individuals are available to them regardless of their point of intake into the system; and 3) there is a minimum of program duplication.

The Student Assistance Program is one example of a joint service. This program, funded through a special state grant program, takes mental health, substance abuse, and education monies to run a program of substance abuse and suicide prevention in the schools. About half of the youth seen in this program ultimately are referred to the Children's Clinic for cross-agency services.

The therapeutic foster care program, CRR, blends several joint funding sources. While it is primarily funded by child welfare dollars available through Title IVE, it also receives some funding from the general county mental health allocation. In addition, staffing is provided through both child welfare and mental health, with case managers being paid for by welfare and the program's supervisor by mental health. Similarly, the Homekeepers intensive in-home service program has mental health, child welfare, and juvenile services-paid staff working in a mental health-based program. Not only does this encourage joint ownership of the program across agency components, but it also creates built-in liaisons between the components. Several of the youth service programs have funding from various sources, and the Parent Center is jointly funded by all of the component agencies of the department.

VIII. CLIENT LEVEL COORDINATION MECHANISMS

The Children's Clinic

The Children's Clinic is the cornerstone of the child mental health programs in Northumberland County. Created in 1984, the Clinic represents a pooling of all county resources that provide services to children. Staff from each of these agencies meet, along with families, on a structured, systematic basis to plan, coordinate, and monitor the services provided to children and adolescents who have multiservice and intensive mental health service intervention needs. This process empowers staff to do treatment planning, utilizing all available resources from every agency and school district. Rather than seeing children and their families as "belonging to" one agency or service component, the Children's Clinic encourages the agencies, services, and families to see themselves as part of a unified team that reconceptualizes the shared ownership of programs for "our children." Since both the family and the primary worker responsible for the care of the family are considered to be part of the Children's Clinic team, the concept of "our children" truly makes sense from both the family's and the line worker's perspectives.

Family participation is a vital aspect of the functioning of the Children's Clinic. Since 1986, family members have been expected to be full participants in the Clinic's process. Family members are seen as vital team members, and are treated as such at meetings. The Children's Clinic philosophy holds that the more one includes the family, the greater the family's investment in the service planning and intervention process. Similarly, parent involvement forces the agencies to be more honest with parents and among themselves. This becomes evident in watching parents who come to an initial Children's Clinic meeting.

Parents tend to arrive feeling wary and apprehensive about the process, but often they leave feeling that, for the first time, their needs were addressed, their input was valued, and they were seen by the rest of the team as an important partner and resource. Central in the Children's Clinic approach toward families is the understanding that blaming other agencies and/or parents for the problems of children is not constructive. Further, if one expects families to take part in solving problems, then solutions cannot be imposed upon them by professional agencies. Rather, families and professionals must work together cooperatively.

The Children's Clinic is chaired by the CASSP Coordinator. As a result, the entire county-wide planning for delivery of services to children with mental health problems and their families is related to the experience of the Clinic. These experiences are directly reflected in needs assessments, planning, and policy formation. At the same time, the philosophies and directions developed through the CASSP Team are added to the practice of the Clinic. This close interaction between planning and service delivery functions has led to an expansion of the continuum of services available, as well as to increased access to services.

The Children's Clinic also acts as a gateway to intensive mental health services as offered by the department's mental health component. There are two important aspects of this gateway function. First, the gate keeping is a voluntary action in that there are no formal rules that require Children's Clinic approval in order to get more than basic-level mental health services. However, the department staff understand that children and families that need more intensive mental health services will benefit from a Children's Clinic review and that this review will ultimately lead to better service planning and availability. Secondly, the severity of a mental health problem is not a criterion for Children's Clinic review. Unlike many other gate keeping mechanisms, children do not have to have severe emotional disturbances in order to receive services through the Clinic. Anyone who has the need for more than basic mental health counseling or needs multiple services has access to the Children's Clinic to and the services that can flow from it.

In addition to using the Children's Clinic for the development of intervention plans, the process is used for consultation about difficult assessment problems and/or service issues. In addition, the members of the Clinic's team use the team for mutual support. Further, other agencies and program components often use the consultation of the Children's Clinic to help them make a determination of need. For example, school personnel sometimes use the Clinic to assist in making determinations of special education status on the basis of serious emotional disturbance. Similarly, Children and Youth Services staff use the team to assist in making placement decisions, and the Children's Clinic is used as the formal body for the determination of emotional abuse.

The Children's Clinic is made up of regular representatives from the various agency components as well as of representatives from outside agencies. Each individual case calls for the participation of that family and of any workers involved with the child and family, and may also call for participation of additional community agencies. Each agency representative is expected and authorized to speak for his or her agency and to commit necessary services and resources as required in the agreed-upon treatment plan.

Regular participants in the Children's Clinic include:

- o Mental Health/Mental Retardation Services
 - Homekeepers (Family-Based Treatment)
 - Northumberland County Counseling Services (Outpatient Psychotherapy)
 - Base Service Unit (Case Management)
- o Children and Youth services
- o Juvenile Court Services
- o Drug and Alcohol Services
- o Department of Human Service Administration
- o Public Schools
- o Guardian Ad Litem
- o Family
- o Worker(s)

Clinic meetings are convened by the CASSP Coordinator and are held weekly at a regularly scheduled time or on an emergency basis when necessary. There are no formal rules for these meetings, and participation is considered voluntary -- all of which has the value of making the process truly participatory with a strong feeling of joint ownership. This has led to a spirit of sharing, which is in stark contrast to the feeling of "dumping" and being "dumped on" that existed in the pre-Children's Clinic era.

The Children's Clinic receives referrals from any one of a number of sources including any one of the agency components of the department as well as the public schools or from the Intermediate Unit. Of particular importance is the understanding that the "child" (him or herself) is not referred. Rather, it is the worker and the family together who are referred for the development of an intervention plan. The referring worker is expected to notify the Clinic's convener of the desire for a Clinic review of a family's service need; the review then is scheduled related to the urgency of need. The only required paper work that accompanies a referral is a referral form which includes a problem statement, a family genogram, and a history of prior services. The referral procedure also requires a formalized risk assessment to be performed using the Risk Factor Matrix. Also required is a release of information across agencies and components of agencies to allow for full participation and discussion.

After initial introductions at the Clinic meeting, both the worker and the family members are given the opportunity to present the problems as they see them. This may include problems in the access and delivery of prior services as seen by the family. Conversely, the worker may note problems of compliance with a treatment plan by individual family members. Honesty and a true lack of blaming can allow this to be a productive interchange that ultimately leads to the discussion of what services now need to be provided.

Group consensus about the treatment plan is reached through sharing and discussion. Program representatives are present to offer the pros and cons of any particular treatment modality. Since the county has developed a wide range of service alternatives, the discussion usually leads to the identification of an array of appropriate and available services. From this, a Family Service Plan is developed.

The Family Service Plan is the document that results from the Children's Clinic team meeting. This document presents the goals of intervention, the services to be provided (with the name of the specific workers), a set objectives (with plans for action), the key responsible person (which could be the parent), and a prospective completion date. The document also includes a section labeled "Methods Used to Involve Parents" which not only reports on family involvement in the planning process, but also reminds the team of the need for meaningful family participation in service delivery. If the child is placed out-of-home, a separate section of the Family Service Plan is completed called the "Placement Amendment." This section includes the reason for placement, efforts to prevent placement, the appropriateness of placement, placement goals, needs for reunification (if appropriate), services to be provided, objectives, and methods used to involve parents in the Family Service Plan. The plan and the amendment both describe the rights of parents to appeal if they do not agree with the plan and will not sign the forms.

Funding of the services specified in a Family Service Plan often becomes an issue. The joint problem-solving capacity of the Children's Clinic team can lead to collective solution of fiscal problems. This, on occasion, includes joint funding of a program or a program component. The emphasis is "What can we do together in order to get this plan implemented?", rather than the more typical, "I can't do it, you have to." There are no flexible funds available to the Children's Clinic at this time, but the department is exploring potential mechanisms for this.

Resolving problems among agencies or agency components is a major part of the Family Service Plan development. When issues cannot be resolved in the team meeting, they are brought to the department director for resolution. The most common problems concern the commitment of services not directly controlled by the participants of the Children's Clinic. For example, the child welfare component, feeling that it has a legal mandate, sometimes may not think that foster care decisions should be made by the Children's Clinic. While most of the time this type of issue is resolved by the team and consensus is reached, there are instances in which the team wishes the child to be placed in foster care and the Children and Youth Services component refuses to make such a placement. At this point, the issue is resolved in consultation with the department director.

The Family Service Plan is reviewed on a periodic basis, as determined in the plan itself. This review is cause for another meeting of the Children's Clinic team involved with the family. At that time, modifications of the plan and its services can be made. A review can also be held on an emergency basis, if necessary. When the need for intensive mental health or multiple services ceases, the family is discharged from the Children's Clinic.

IX. SYSTEM OF CARE ACTIVITIES

Family Involvement

Perhaps the most important aspect of the Northumberland County system of care is the integral role of families. The underlying philosophy of the system of care is that natural families are the most important resource for a child or adolescent. Even in those instances

when youngsters cannot live at home, the family is included in the service planning and delivery process. The Children's Clinic operates with the parents as team members. While most parents approach the Clinic with some fear and trepidation, the process has been constructed in such a way that, by the end of the first Clinic meeting about their child, the parents have been made to feel that their input is vital to the process and that their concerns about the services to be provided to them and their child have been addressed. While parents do not always completely agree with the final service plan for their family, they do leave the Clinic meeting knowing that they have been heard and understanding why the majority of the Clinic team feels that a certain plan is valid within the context of the parent's objections. While such parent/professional team efforts are theoretically sound, many similar teams across the nation may struggle because the professionals have difficulty fully accepting the role of the parents and may appear patronizing or condescending as they tell the family what the service plan should be. This does not occur in the Children's Clinic where the family-based philosophy appears to be fully accepted by the professionals. The Clinic is currently exploring the feasibility of making a parent, or parent representative, a regular member.

Another reflection of the family-based focus of the system of care is the predominance of service components that stress family involvement. All outpatient mental health services are offered from a family therapy perspective. A new emphasis in foster care is to have foster parents work with natural parents in an effort to facilitate reunification. The newest program of the agency is the Parent Center which is run by parents and provides support and training to enhance parenting skills.

The development of a family support groups for parents of children with severe emotional disturbances has been slow. While the system understands the need for this kind of vehicle, the degree of involvement of parents in the Children's Clinic and the Parent Center has heightened awareness of the need for a parent support network. It is anticipated that such a parent support/advocacy group will be developed in the near future.

Cultural Competence

One of the glaring gaps in the Northumberland County system of care is in the area of cultural competence. County human service professionals readily agree that they have little to offer the small minority population in the county. They are aware of the growing Hispanic population leaving New York City and migrating to the county, and they know that the agency lacks staff that is culturally competent to work with this specific population that is struggling with ethnic issues as well as the transition from an urban to a rural environment. They are further aware that in a county with a 99.6 percent white population, minority group members' needs often are overlooked. Plans are currently in place to provide some training on cultural issues.

Transition

Adolescents who are ready to transition from families to independent living and from children's to adult services are supported by several programs in the Northumberland County system of care. Transitions from children's to adult services are made easier in this system by virtue of the unified nature of the agency and the representation of all agency components in the Children's Clinic. The limited size of the county and the Department of Human

Services also makes the informal connections between agencies work better for youth who are transitioning from one service to another.

Specific programs that facilitate transition, all described previously, are not necessarily labeled as such, yet have features that serve this purpose. CLANCY, for example, has a rehabilitation focus that helps teach independent living and social skills, offers a GED, and provides job training and job coaching. Transitioning adolescents are prime beneficiaries of these services, although younger adolescents also partake of them. Additionally, Children and Youth Services offers an Independent Living Program for older adolescents who are getting ready for emancipation.

Populations at High Risk

While most of the traditional high-risk groups such as homeless/runaway youth, those who are HIV infected or at risk for AIDS, and children of parents with chronic mental illness are not of great prevalence in Northumberland County, it is noteworthy that the Department of Human Services has developed the capacity to deliver services to youth through an alternative service mechanism. This is done within the agency through the CLANCY Program which was created to meet the needs of youth who were not benefiting from the traditional agency services. Alternative services initially took the form of day treatment and special alternative schooling, but have been expanded to include the transition programs mentioned above, therapeutic camp, and other programs that work with youth who have been alienated and/or do not respond well to more traditional services. CLANCY has the capacity to change its programs to meet the changing needs of the youth that it serves. With this type of alternative service structure, the system of care is in a good position to create those services that might be needed by any high-risk group that becomes evident in the county.

Advocacy

Advocacy for children and adolescents with severe emotional disturbances in Northumberland County is primarily focused on CASSP. The CASSP Coordinator has the role of convening the appropriate advocates in the community to create and put forth an advocacy agenda. This activity has included all participants in the service system including program management and service delivery personnel and consumers. The CASSP Team also has an ongoing needs assessment function, identifying service gaps that need attention.

The Central Susquehanna Alliance for the Mentally Ill, an affiliate of the National Alliance for the Mentally Ill (NAMI), had been a strong force in Northumberland County over the last 10 years, but no Alliance for the Mentally Ill-Child and Adolescent Network (AMI-CAN) or Parents In Need (PIN) groups have been started in the county. The county recognizes the need for a parent advocacy group to assist in the further development of the system of care.

X. FINANCING

The Northumberland County Department of Human Services uses traditional funding streams for the financing of its services. Through a series of state block grants, state

categorical grants, and allocations of local tax dollars, it weaves together the funding for an array of services. Categorical dollars are used to fund the programs for which they are mandated. The agency uses the greatest amount of flexibility possible in moving these mandated funds into programs that qualify, often using innovative thinking to do so. State block grants are used to fund the basic mental health, mental retardation, child welfare, and juvenile justice programs, with the remainder being used to fund new initiatives, unsupported liaison and training functions, and to fill in when funding for other components runs short. For the mental health components of the system, the major funding source is the state mental health/mental retardation allocation. Out of this comes the funding for the Base Service Unit and some of the services offered by NCCS.

Most of the treatment plans developed by the Children's Clinic are jointly funded. This occurs through each agency component or community agency outside of the Department of Human Services agreeing to pick up the cost of the care under its component. For example, a family may require mental health treatment which is provided in NCCS by mental health and may also need shelter or respite which is provided by Children and Youth Services.

Several programs are jointly funded. The most prominent of these is the Community Residential Rehabilitation (CRR) Host Home Program of therapeutic foster care. This program is shared by mental health and child welfare through both joint funding and joint staffing. For each day of care, Children and Youth Services provides \$20 (using Title IVE dollars) and Mental Health \$4 (using the block allocation). In addition, Juvenile Court Services can provide funds for its children in CRR through the use of Title IVE funds available to them. The program has staff primarily provided by Children and Youth Services, but the coordinator, who also acts as the clinical supervisor, is paid by mental health. While Homekeepers, the intensive mental health home-based treatment program, is fully funded by a categorical state mental health grant, it, too, is jointly staffed, with one of its three family workers supported by Children and Youth Services.

The CLANCY alternative youth program is jointly funded in another way. This program is made up of several component programs which act together to meet a variety of the needs of the youth that it serves. These include job training, counseling, GED service, day camp, and social skills training. Various program elements are funded by different agency components, often with categorical grants. While this program administratively sits in a Special Services Unit of the Juvenile Court Services component of the agency and most of its services are funded with juvenile probation funds, the social rehabilitation program is funded at \$50,000 through mental health. Additionally, CLANCY serves youth from all components of the agency who are referred through the Children's Clinic, regardless of whether or not they are committed to Juvenile Court Services.

The Parent Center is another jointly funded program. Originally funded by a grant from the Governor's Drug Council, it currently is funded by Mental Health, Children and Youth, and Drug and Alcohol Services. The county blends discretionary funds from each of these budgets to support the staffing and other expenses for this new program.

The Student Assistance Program (SAP) is a state program for working with at-risk students in schools. It is funded through a state blending of drug and alcohol, mental health, and education dollars. While this is not local blending of funds, it acts as a model in the

community for this type of program. One of the gaps within the county system is that neither the school districts nor the Intermediate Unit for special education have participated in joint funding with Human Services beyond the SAP. This has been further complicated by the duplication of day treatment services by the Human Services Agency and the schools. However, through the schools' participation in the Children's Clinic, it is anticipated that the schools and the Intermediate Unit will become better partners in the future.

There currently is no capacity for flexible funding of services or pooling of funds for special use on an individual case basis. On some occasions, petty cash funds are used to meet some needs that are not covered by the programs in the system. This does not afford a great deal of flexibility, and the lack of this type of resource is seen as a gap by the system.

XI. EVALUATION

While there has been no formal evaluation of the Northumberland County system of care, the Department of Human Services has developed a Management Information System (MIS) that offers adequate capacity to track the success of most system components and to track the major system outcome measures -- the reduction of out-of-home placement and the eradication of institutional placements. The Human Services Management Team understands the importance of data in planning for current and future programming and feels strongly that data is vital in the justification of spending funds on new and innovative programs. There is an understanding that in both planning and program development areas, only strongly supported outcome data will allow continued growth in new directions.

The Human Services Department has committed significant resources in the last several years to the development of a cross-agency MIS. Funded originally through a state crime and delinquency grant, this MIS provides an interactive database across each of the Department of Human Services component agencies. Each categorical program has a specialized information system to meet its own unique needs, and there is also an interactive cross-system mechanism which allows for tracking of children and families across the various component agencies. While it feels that it has made great strides in the area of MIS, the agency thinks that the sophistication of the MIS should be increased in order to better track individual children and families within and across service components. Ultimately, the department hopes to improve the system to the point where it can integrate the MIS with one currently in use in the special education Intermediate Unit (the Intermediate Unit Special Education Child Tracking System) and, ultimately, with the local school district information systems.

A primary measure of system effectiveness has been the reduction and virtual elimination of institutional placements and hospitalizations. While not a sophisticated mechanism, the Human Services Management Team and the Children's Clinic use this basic data to track the success of the system. They work from an assumption that community-based, home-based, and family-centered care leads to equal, if not better, outcomes than a system that supports more institutional options. The data used to confirm this assumption are primarily anecdotal and based on clinicians' impressions of how the children and families do relative to how they did under the old system.

County data demonstrate that the current service continuum and related coordination and individualized service planning mechanisms have resulted in significant reduction of restrictive residential placements. The number of residential/institutional programs dropped from 12 in 1985 to none in 1990 and 1991. Similarly, group home placements have been eliminated, from two to four in 1985-1986 to none since 1988. The use of Medicaid dollars to fund hospitalizations has dropped over the same period of time from a high of \$148,000 in 1986-1987 to \$65,000 in 1990-1991.

This drop in utilization of the most restrictive placements was at first reflected in an increase in county-operated and county-purchased foster care placements, which peaked at 220 in 1987. This is related to the use of both regular and therapeutic foster care by the system, and reflects the capacity to keep more disturbed children in these types of placements through the availability of supportive services obtained through the Children's Clinic. With the advent of Homekeepers and other home-based services, the number of foster care placements has now dropped below 120. These reduced numbers include increased utilization of foster care for crisis shelter placement, respite for children and/or families, and intensive therapeutic placements as well as for traditional protective placements. With these new uses of foster care considered, the relative numbers of foster care placements has actually fallen to a greater extent than the numbers indicate on the surface.

XII. MAJOR STRENGTHS AND CHALLENGES

Participants representing each of the agency components and other community constituencies in the Northumberland County system of care have identified several factors that drive the system and have made it successful. The major strengths of the Northumberland County system include the following:

- o **Leadership** - Far and away the most commonly stated factor influencing the success of the development and continuation of the Northumberland County system is its leadership. Beginning with the feeling among agency directors that the system was not working, and mirrored by the desire of the County Commissioners for a more responsive system, the county began in the mid-1980's to move ahead toward a new system of care. The vesting of power by the County Commissioners in the right individual at the crucial first moments of system's change was a most important factor in the development of the system's vision, structure, and acceptance by the agency directors. That individual not only reflected the prevailing spirit of the need for change, but also added two vital ingredients. The first of these was the ability to make the kinds of deals with the Commissioners that would consolidate the system's components. The second was the capacity to convince other individuals in leadership positions that, by joining together under his leadership, they would all move toward their goal of a more functional system of care. To do this, the director relied on his own vision of the system and a management structure which shared the power in a nonthreatening way, while at the same time acting as a strong and powerful leader.
- o **System Management** - The system, as it has developed, has a unique management style that is generally accepted as a strength. The management of the system

operates at several interactive levels. The first of these is the Human Services Management Team which consists of the directors of the various agency components of the Department of Human Services. It regularly reviews the service needs that are identified by the Children's Clinic and by the other multidisciplinary service planning systems which have developed. This team serves as the focal point for all policy development and refinement within the Department of Human Services. The team has the capacity to work together creatively on such issues as cross-system training and blended funding as well as on the planning for new agency components. The development of the Parent Center is an example of how system needs can be solved by joint decision making and funding.

A second level of management is the Quality Circle process which is the annual self-assessment conducted by the department. Through this process, staff at all levels within the agency are encouraged to work together to identify weakness and utilize existing talents within the agency to correct them. This process not only empowers staff at all levels to feel part of the decision making process, but also requires the upper level management to be responsive to the assessment and development capacity of the entire agency. This process ultimately lets all staff feel as though the department is "their" agency and that their concerns about children and families can and will be heard and addressed.

The Children's Clinic is another level of management. While created as a clinical coordination and not as a management tool, the Clinic operates in a way that encourages creativity in system planning in addition to developing individual treatment plans. The directors of the various component agencies are represented and often personally sit in on Children's Clinic meetings. As noted, input from these meetings regarding system gaps and problems is immediately fed back to the Human Services Management Team. Thus, policy making and clinical practice have constant interaction, assuring that the policy decisions are relevant to clinical and other family needs. Through their participation in the Children's Clinic, parents and other agencies, especially the schools, have access to the decision making of the Human Services Management Team.

A fourth level of management of the system comes through the local CASSP Team. Like the Children's Clinic, representation on CASSP includes not only the directors of the agency components of the department, but also representatives of the school districts and the Special Education Intermediate Unit. Within the context of the CASSP Team, each of these agencies has an impact on the decision making of the system of care. As the CASSP Team has developed, the participants have felt that it has acted as a conscience for the system.

- o **Problem-Solving Approach** - The style of management in the Northumberland County system encourages a problem-solving approach that is empowered by the system. Frequently heard in interviews with upper management were comments on their expectations of line staff such as, "Let them do it;" "Creativity is more than valued, it is expected;" and "Do what you have to." Inherent in these phrases is the understanding that the staff are in touch with the needs of children and families and that the system is there to meet those needs. The system then must be created and

directed in a manner that enables the staff to do what is necessary, even when that means bending or even changing the system. System boundaries and regulations generally are seen as barriers, and the prevailing approach is to tear down or defeat them when necessary.

- o **Shared Vision** - Among the leaders and staff of the Department of Human Services is a unitary vision which is seen as a strength in the system. Since at least 1984, the system has been driven by individuals who have shared certain understandings of what the delivery of services is all about. With a degree of luck and natural attrition, the system is currently staffed with a vast majority of individuals that have a shared mission. The most important aspects of this shared vision are that: 1) families are first; 2) services should be provided in the community; 3) the system is in place to serve the needs of individuals and families in the community; and 4) the needs of the on-line providers of services also must be met. As one division director stated, "Who is the client? It is the community, the providers, and the families!" With the CASSP Team acting as the watchdog and conscience of the system, these principles are in constant discussion. There appears to be an implicit understanding that if the vision is not always kept prominent, that the system will have a natural bureaucratic tendency to revert.
- o **Unique Concept of the Continuum of Care** - The Northumberland County system operates its services with a unique understanding of the continuum of care. Rather than working from the assumption that the least intensive intervention is outpatient psychotherapy, there are several less-intensive levels. These levels include services such as referral, assessment, crisis intervention, basic-level case management, at-risk groups, AA, and parent skills groups. The result of this conceptualization of the continuum of care is that every case worker, teacher, or other worker is included as an important member of the team, regardless of the fact that he or she is not performing interventions that are traditionally seen as "therapy." Each worker and each service can and will be of use in various individual intervention plans.
- o **Family Focus and Parent Participation** - The participants in this system truly believe that the family is the most important resource for a child. This basic premise leads to the understanding that services should meet the needs of the family and that the family must be part of the system in order for this to occur. Unlike many settings in which the family-centered rhetoric is not reflected in interactions with families, in Northumberland County, professionals work with families to encourage them to be part of the system and to believe that the system is geared to meet their needs. Many of these families have had negative experiences with the system in the past, and there is a heavy burden on the current system to prove that it is different. The family-oriented vision keeps the whole system on track.
- o **Community Characteristics** - The people who live and work in Northumberland County see themselves as tough. One described their "coal region stamina" as a major factor in tackling the difficult job of meeting the needs of troubled families. This feeling of self- and community-reliance has brought people together to make the best out of what was felt to be a terribly inadequate system of care. The building of the

current system has taken a great amount of effort, and the people of this community have been more than up to the task.

In spite of the success of the system building efforts in the county, several issues have yet to be resolved. These include:

- o **Categorical Agency Regulations** - The participants in the system feel bound by categorical restraints placed upon them by state funding streams and legalities. The most frequently cited problem is the one presented by foster care regulations. The system uses foster care and therapeutic foster care to meet many needs. However, these services are funded through child welfare and are bound by state child welfare regulations. This means that any child or adolescent who needs placement in such a setting for more than 30 days must be committed by the court to the department's child welfare programs. While ability to place for an initial 30 days without commitment is longer than in many states, and most placements can be terminated within this time period, this regulation still places a burden on the system that is contrary to its philosophy. These conflicts between regulation and system philosophy impede system development.
- o **A Formal Gateway to More Intensive Services** - Regardless of the success of the Children's Clinic in reducing institutional placements, the lack of a formal gatekeeper in the county system allows the schools and private sector agencies to continue to make restrictive placements. Until this type of mechanism can be developed for all parts of the service system, there will be cases that are placed in long-term residential and hospital programs instead of receiving the less restrictive services that are available in the system of care.
- o **Turnover** - A frequently mentioned problem in the system of care is staff turnover. In spite of the management structures and the shared vision which encourage empowerment of staff, certain jobs in the system lead to burn out. This is especially true of the more traditional child protection positions. These workers rarely are afforded the luxury of being part of the exciting new system because they are too busy coping with an ever-growing problem of child abuse and neglect. Even this innovative service system has not determined how to expand some of its exciting philosophy and support to this overworked segment of the staff. Another aspect of turnover relates to the national problem of underpayment of human service workers, especially in public systems. This is true in Northumberland County as well, where there is competition both in terms of pay and excitement with larger cities in the state.
- o **Lagging Agencies** - While the Department of Human Services' components all have become active partners in the system of care and all of its coordination and management structures, some community agencies have been slower in becoming willing partners. This has been especially true with the school districts, the Intermediate Unit, and the programs at the Geisinger Medical Center. The schools were slow to see the Children's Clinic as a gateway for their more intensive services. However, over time the benefits of participation and the success of joint programming have become apparent, and they are now becoming more active partners. The Geisinger Hospital's mental health programs still tend to operate outside of the

system of care. While it is true that the medical staff of the hospital work as medical/psychiatric consultants to this system, they are not members of the Children's Clinic or the CASSP Team.

The most evident result of reluctant participation by some community agencies has been the duplication of services. Day treatment/day school programs have been run by the Department of Human Services' CLANCY program for many years. Yet the public school Intermediate Unit has recently set up its own Day School Program, and the Geisinger Hospital has also instituted a Day Treatment Program. The system of care would be better served if all service providers saw themselves as part of the system and planned services jointly.

- o **Cultural Competence** - The county has a rapidly expanding minority population and feels that it has not adapted its services to be delivered in a culturally competent manner. It hopes to hire more minority staff and to train current staff on cultural and ethnic issues. However, it is difficult to recruit minority professionals to live in rural areas with a vastly white majority.
- o **Flexible Funding** - A pool of flexible funds is felt to be needed to afford the Children's Clinic full creativity in implementing appropriate and responsive service plans. These noncategorical funds would support services to children not eligible for Medical Assistance or for third party support. Flexible funds would also allow the provision of nontraditional services which are not funded through any existing funding streams and which are unavailable in the current continuum of care.
- o **Short-Term Crisis Hospitalization** - There are currently no psychiatric beds for younger children within 60 miles of the county. On those rare occasions in which it is necessary to hospitalize a child under age 12, resources must be sought outside of the community. This is felt to disrupt the service plan and to defeat the family-centered, community-based philosophy of the system of care. Currently, the only alternative is therapeutic foster care.
- o **Parent Support and Advocacy** - In a system that places such a high priority on the participation of parents in the care of their children, it is curious that a strong parent support and advocacy network has not developed. This may be due to the fact that the inclusion of families in the system has been so effective that a parent network has not been necessary and, therefore, has not been seen as a high priority in the development of the system. However, the participants in the system currently feel that such a parent advocacy and support capacity is important as the system develops further and plan to facilitate the development of this capacity in the future.

Beginning in 1992, the county has obtained a new grant from the state which will provide services to address many of the weaknesses identified by the system. This Living In Family Environment (LIFE) grant will provide funds to do the following:

- o **Enhance the "Gatekeeping" Function** - While there has been considerable success in reducing the need for hospitalization for children and adolescents served in the private sector, this grant will create a "managed care capacity" in the county by hiring

a consultant to work with a variety of insurance carriers and health maintenance organizations to encourage them to buy hospital diversion services from the county system of care.

- o **Increase Family Support Services** - To enhance family support services, the new grant will allow the implementation of a family-driven cash support model which will provide a specific cash payment to families of emotionally disturbed children and adolescents to enable them to secure appropriate support services, including respite. This would be similar to a current program for families served by the mental retardation system.
- o **Enhance Cultural Competency** - The increasing minority population necessitates a comprehensive, ongoing training program to develop an understanding of cultural differences and to increase the ability of staff to appropriately meet the special needs of the minority population. Beyond training, the project aims to appoint minority group members to various policy groups and to recruit minority staff.
- o **Enhance Intensive Case Management and Homekeepers Services** - It is recognized that the demand for these services is growing and, in order to meet county mandates for service, the capacity to provide them must be expanded to prevent future institutionalization.
- o **Expand and Develop an Array of School-Based Services** - The geographic characteristics of the county continue to impede access to centrally delivered services. The development and expansion of services in the schools will serve as a vehicle to decentralize services in each of the communities in the county and to make them readily available to children and families in their own communities. This will include expanding the group counseling services currently provided in all school districts. Increased liaison with the schools generated by these services will lead to more opportunities for working jointly toward expanded training and toward increased school-based services. An example of a program under consideration is social rehabilitation with a built-in opportunity for outward bound experiences.
- o **Develop an Integrated Management Information System** - Under the new grant, the county will enhance the capacity of its MIS to track children and families across agencies and within the department. The improvements will allow the Department of Human Services to better monitor its service capacity needs and, ultimately, will lead to the integration of human service and special education data systems.
- o **Develop Short-Term Hospital Crisis Stabilization Capacity** - The grant will allow the development of an alternative method for providing short-term inpatient crisis stabilization services for children under the age of 12. This will, hopefully, involve the use of general pediatric beds in the Geisinger Hospital, with added support for the child and staff.

One of the strengths of a system is the ability to recognize its weaknesses and to be able to continue to build the system in order to overcome those deficits. This is one of the clear strengths of the Northumberland County system. Regardless of the degree of success that

already has been attained, the county is working to fill the identified gaps. Its management structure also encourages the system to change as the needs of the community change. The accomplishments of this system of care are the result of hard work, constant negotiation, and constructive response to ongoing change. These accomplishments did not occur overnight. Rather, they have been the result of many months and years of building on what and who was there, and then building again upon these results, and then building again. The system that is now in place could not have been conceived of in 1984 when the change process began, and the system that is in place in the year 2000 will, hopefully, be equally innovative.

XIII. TECHNICAL ASSISTANCE RESOURCES

Northumberland County has developed significant expertise in providing technical assistance and consultation to other counties in their efforts to develop a coordinated service delivery system and to enhance their system of care. The county human services management staff is committed to increasing its ability to convey the various outcomes and technologies which have enabled them to improve their service capacity. They have developed some technical assistance information concerning the Children's Clinic including a video describing the Clinic and a brochure, "Service Description of the Children's Clinic." Additionally, staff are in the process of developing a set of handouts for parents on early intervention services.

**NORTHUMBERLAND COUNTY
CHILDREN'S CLINIC**

CLIENT INFORMATION:

Client: ----- (last) (first) (m)

Case Status: Active _____

Address: _____

City: _____

Phone Number: (____) ____-_____

School or Employment:

Date of Birth: ____/____/_____
(mm) (dd) (yyyy)

Age at time of Referral: ____

FAMILY BACKGROUND INFORMATION:

Father: _____
(first last)

Home Phone: (____) ____-____

Address: _____

Work Phone: (____) ____-_____

City: _____

Mother: _____
(first last)

Home Phone: (____) ____-_____

Address: _____

Work Phone: (____) ____-_____

City: _____

Guardian: _____
(first last)

Home Phone: (____) ____-_____

Address: _____

Work Phone: (____) ____-____

City: _____

Relationship: _____

Child lives with: _____

SIBLINGS IN AND OUT OF HOME / OTHER INDIVIDUALS LIVING WITH CLIENT					Relationship to Client	Lives with Client?
Name of Individual	Sex	Birth Date (m) (d) (y)	Age			
1. _____ (first last)	M F	___/___/___ (m) (d) (y)	___	-----	-----	Y N
2. _____	M F	___/___/___	___	-----	-----	Y N
3. _____	M F	___/___/___	___	-----	-----	Y N
4. _____	M F	___/___/___	___	-----	-----	Y N
5. _____	M F	___/___/___	___	-----	-----	Y N
6. _____	M F	___/___/___	___	-----	-----	Y N
7. _____	M F	___/___/___	___	-----	-----	Y N
8. _____	M F	___/___/___	___	-----	-----	Y N

PRESENTING PROBLEMS

A set of eight horizontal lines for handwriting practice. The lines consist of a solid top line, a dashed midline, and a solid bottom line. A small red dot is positioned at the right end of the dashed midline.

REFERRAL SOURCE:

Case Manager: _____
(first last)

Agency Name: _____

Address: _____

City/State/Zip: _____

Work Phone: (____) ____-_____

SCHEDULED EVENT

Date

Time

Referral Received: ____/____/_____
(m) (d) (y)

Intake Scheduled: ____/____/_____ ____:<____
 (h) (m) (AM, PM, NOON)

Intake Completed: ___/___/_____

Clinic Staffing: ___/___/_____ ___:_:_

SIGNIFICANT OTHER AGENCY/SCHOOL/INDIVIDUAL INVOLVEMENT:

Name: _____ Relationship: _____
(first last)

Address: _____

Address: _____

Home Phone: (____) ____-_____

City: _____

Work Phone: (____) ____-_____

Name: _____
(first last)

Relationship: _____

Address: _____

Digitized by srujanika@gmail.com

Address: _____

Home Phone: (____) ____-____

City: Montgomery **State:** Ala. **Zip:** 36104-5114

Work Phone: (____) _____-_____

NORTHUMBERLAND COUNTY HUMAN SERVICES

CHILDREN'S CLINIC AUTHORIZATION

Re: Client: _____ BSU#: _____
Address: _____ DOB: _____
_____ SS#: _____

The purpose of the Children's Clinic is to streamline the delivery of services in an effective and efficient manner which will best meet a client's needs. The Clinic is also designed to draw out and develop an effective individual treatment plan through the cooperative effort of all the team members.

The Northumberland County Children's Clinic is a multi-disciplinary team composed of the following service entities:

Northumberland County Mental Health/Mental Retardation
Northumberland County Children & Youth Services
Northumberland County Drug & Alcohol
Northumberland County Counseling Services
Northumberland County Homekeepers Program
Northumberland County Juvenile Court Services
Child Adolescent Service System Program (C.A.S.S.P.)
Central Susquehanna Intermediate Unit
Northumberland County Special Counsel
Additional Agencies: _____

Parent involvement is sought and encouraged within the Children's Clinic. Parents are incorporated into the Clinic process as full partners on the service delivery team. It is our belief that parents are the most significant part of any treatment team, therefore your values, needs, and viewpoints are a crucial resource in developing the treatment plan.

I hereby authorize the Northumberland County Children's Clinic to hold a case staffing review with all of the above listed multi-disciplinary team members involved in the clinic process. I also authorize Children's Clinic members to share pertinent case information with each other between and among Clinic participants. I understand that all information discussed within the Clinic process is confidential and may only be divulged to those participants/service entities listed above. I understand that certain records and other case information that may be in the possession of Children and Youth Services would be considered confidential by law and I understand that I will be required to sign a separate authorization for release of information with Children and Youth Services to allow those items to be used in the Clinic process. I further understand that this Release and Authorization will remain in effect for a period of six (6) months.

DATE

SIGNATURE OF CLIENT, RESPONSIBLE RELATIVE
OR LEGALLY APPOINTED GUARDIAN OF THE PERSON
(AS APPROPRIATE)

ITNESS

FAMILY SERVICE PLAN

1. Family Name _____

2. Case Number

**3. Date Accepted
for Service**

4. Identifying Information

5. Reasons for Accepting the Case. (Describe A. the specific situation or conditions, B. their effect on the children, C. any contributing factors).

Page 2 - Family Service Plan

6. Date of Plan ____ / ____ / ____

Period Covered by the Plan _____ to _____

7. Goals (Check all appropriate goals)

Improve living conditions

Prevent re-abuse of child(ren)

Improve child supervision
or care

Prevent placement of child(ren)

Improve behavior of
child(ren)

Return child to family

Other _____

8. Problems and Needs Addressed by this Plan.

9. Services to be Provided

County Children and Youth Agency Services

_____	_____
_____	_____
_____	_____

Services Provided by Other Agencies

Type of Service	Name of Service Provider
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

NOTICE OF PARENTS RIGHT TO APPEAL

If you do not agree with the Plan, you may appeal to the Office of the Hearings and Appeals, Department of Public Welfare, any part of the Plan, Plan Amendment or Plan Review which:

- (1) results in a denial, reduction, discontinuance, suspension or termination of a service, or
- (2) fails to act upon your request for service with reasonable promptness.

If you wish to appeal to the Department of Public Welfare, you have 15 days from the date you receive this notice to notify Children and Youth Services in writing. The Agency will forward your appeal to the Department of Public Welfare. While the appeal is being decided, the current service plan will remain in effect.

If you decide to appeal, you have the right to be represented by an attorney or other representative. If you wish to be represented by an attorney and you cannot afford one, you should contact:

Susquehanna Legal Services
206 Arch Street
Sunbury, PA 17801
Telephone: 286-5687

You should understand that a ruling on an appeal by the Department of Public Welfare will not overrule any portion of a Service Plan, Plan Amendment or Plan Review specifically approved or ordered by the Court.

If the Court is involved with your case, you have the right to petition the Court regarding any action of Children and Youth Services affecting your child.

In the event that your child/ren is now or would be placed in temporary foster care with Northumberland County Children and Youth Services, you are entitled to know that:

- A. the emergency on-call telephone number providing 24 hour access to our Agency is 1-800-222-9016.
- B. the opportunity for visits between you and your child/ren will be provided at least once every two weeks unless the visits would not be in keeping with the placement goals.

** Parents may refuse, in writing, wanting visitation with their child/ren.

CC

14. Methods Used to Involve Parents (describe the methods provided (e.g. visit, office conference etc.) for parents, children, their representatives, and service providers to participate in the development or amendment of the service plan or placement amendment. Include how and when parents and others were notified of the opportunity to participate.)

15. Signatures

PARENTS/GUARDIANS, PLEASE NOTE: Signing constitutes your agreement with the service plan or placement amendment. Information about your right to appeal this plan is printed on the back of this page.

Signature Date

Father/Legal Guardian _____

Mother/Legal Guardian _____

(If not signed by parents, indicate reason on signature line.)

Children (If 14 years or older)

Signature Date Signature Date

Case Manager _____

Casework Supervisor _____

16. Copies of this Plan were provided to:

Father/Legal Guardian Child/ren (as appropriate)
 Mother/Legal Guardian Family Representative
 Other (specify) _____

17. Scheduled Review Date _____ / _____
Month Year

FAMILY SERVICE PLAN
PLACEMENT AMENDMENT

1. Child's Name _____
2. Case Number _____
3. Child's Birthdate _____
4. Date of Placement _____
5. Family Surname _____
(If different from child's)
6. Date of Amendment _____
7. Emergency Placement (yes/no) _____
8. Reasons for Placement (Describe A. Specific behaviors or conditions; B. Risk to the child, family or community; C. Any contributing factors.)
9. Efforts to Prevent Placement (Identify services provided to prevent placement or describe the conditions which prevented the delivery of services.)

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Page 2 - Placement Amendment

8. Type of Placement (Check appropriate box)

<input type="checkbox"/>	Emergency Shelter	<input type="checkbox"/>	Institutional	<input type="checkbox"/>	Supervised Indep. Living
<input type="checkbox"/>	Foster Family Home	<input type="checkbox"/>	Home of Relative		
<input type="checkbox"/>	Community Residential	<input type="checkbox"/>	Other _____		

9. Location of Placement

10. Appropriateness of Placement

- (a) Describe any special care required because of the child's needs or problems.

- (b) Describe how the placement setting provides for the special needs of the child and why the placement setting is the least restrictive, most family-like alternative possible.

- (c) Give the distance between the child's own home and placement in miles or traveling time.

_____ Miles _____ Time

- (d) Discuss how the distance of placement from child's own home will affect the ability of parents to visit the child.

11. Anticipated Length of Placement: _____ months

12. Child's Known Educational Information

A. Name and address of educational provider

B. Child's current grade: _____

C. Child's current grade level performance: _____

D. Child's school record (please attach to the Amendment, a copy of the child's most current report card and/or other pertinent school records.)

E. Is the Child's placement location in the same school district?

YES NO

F. If no, please describe the reasons necessitating placement into another school district.

G. Other relevant educational information

13. The Child's Known Health Information:

A. List Names and Addresses of the Child's Health Providers (family doctor, dentist, hospital, etc.)

B. Disability Documentation

1. Is this child disabled physically? Yes No

2. If yes, specification of the nature of the disability.

3. Describe how this disability has been documented.

4. Is this child disabled emotionally? Yes No

5. If yes, specification of the nature of the disability.

6. Describe how this disability has been documented.

7. Is this child disabled mentally? Yes No

8. If yes, specification of the nature of the disability.

9. Describe how this disability has been documented.

C. List of Child's Medications

D. Record of Child's Immunizations (Describe A. Known vaccines given and their dates, B. Describe how has the record of the child's immunization been documented, C. If no current documented record is available, please describe efforts made and being made to obtain documented immunization record.)

VACCINE	ENTER MONTH, DAY, AND YEAR EACH IMMUNIZATION WAS GIVEN DOSES				
	1	2	3	4	5
Diphtheria and Tetanus*	1	2	3	4	5
Polio**	1	2	3	4	5 /
Measles (Hard, Red)	1	or Measles Serology: Date _____ Titer _____			
Rubella (German Measles)	1	or Rubella Serology: Date _____ Titer _____			
Mumps	1	or Mumps disease diagnosed by a physician Date _____			
Other:	Other:	/	/	Other:	/ /

E. Other Relevant Health Information

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Page 6 - Placement Amendment

14. Date of Amendment _____ / _____ / _____
Period Covered by the Amendment _____ to _____

15. Placement Goal (check one box)

- | | | | |
|--------------------------|---------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | Return to own home | <input type="checkbox"/> | Place with legal guardian |
| <input type="checkbox"/> | Place with relative | <input type="checkbox"/> | Independent Living |
| <input type="checkbox"/> | Adoption | <input type="checkbox"/> | Long-Term foster care |

16. Appropriateness of Independent Living Services (If the child is 16 years of age or older, and independent living services are deemed inappropriate, please describe the basis for this choice.)

17. Problems and Needs (other than medical and educational)

18. Services to be Provided

County Children and Youth Agency Services:

Services Provided by Other Agencies:

Type of Service	Name of Service Provider

Page 8 - Placement Amendment

Date of Amendment _____/_____/_____

Page 9 - Placement Amendment

23. Review Schedule (Identify the month and year the next six-month placement review is due.)

month / year month / year month / year month / year month / year

24. Visiting Plan

PARENTS/GUARDIANS, PLEASE NOTE: You have the opportunity to visit your child at least once every two weeks, unless:

Visiting does not agree with the goal established for your child,

Visiting is limited by a Court Order. Date of Order:

The goal for the child is adoption or independent living and visitation is not in the child's best interest.

Parental visits are restricted by Court Order. Date of Order:

24. Describe the Visitation Plan (who, frequency, when, location, and imposed conditions.)

25. Except for emergencies or if parents cannot be located, parents and child will be notified prior to any change in visiting arrangements or the physical location of the child's placement.

Indicate any changes to visiting arrangements or the location of placement below and give the date the changes occurred and the date the parents and child were notified.

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Page 10 - Placement Amendment

29. Methods Used to Involve Parents: (Describe the methods provided (e.g. visit, office conference, etc.), for parents, children, their representatives, and service providers to participate in the development or amendment of the Service Plan or Placement Amendment. Include how and when parents and others were notified of the opportunity to participate.)

30. Signatures:

PARENTS/GUARDIANS, PLEASE NOTE: Signing constitutes your agreement with the Service Plan or Placement Amendment. Information about your right to appeal this Plan is printed on the following page of this Plan.

Signature

Date

Father/Legal Guardian _____

Mother/Legal Guardian _____

(If not signed by parents, indicate reason on signature line.)

Child (If 14 years or older)

Signature

Date

Case Manager _____ Date _____

Casework Supervisor _____ Date _____

31. Copies of This Plan Were Provided To:

Father/Legal Guardian Child/ren (as appropriate)

Mother/Legal Guardian Family Representative

Foster Parents _____

Others (specify) _____

Notice of Parents' Right to Appeal

If you do not agree with this Plan, you may appeal to the Office of the Hearings and Appeals, Department of Public Welfare, any part of the Plan, Plan Amendment, or Plan Review which:

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2. fails to act upon your request for service with reasonable promptness.

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Susquehanna Legal Services
206 Arch Street
Sunbury, Pennsylvania 17801
Telephone: 717-286-5687

You should understand that a ruling on an appeal by the Department of Public Welfare will not overrule any portion of the Service Plan, Plan Amendment, or Plan Review specifically approved or Ordered by the Court.

If the Court is involved with your case, you have the right to petition the Court regarding any action of Children and Youth Services affecting your child.

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1. the emergency on-call telephone number providing 24-hour access to our Agency is 1-800-222-9016;
2. The opportunity for visits between you and your child/ren will be provided at least once every two weeks unless the visits would not be in keeping with the placement goals.

** Parents may refuse, in writing, wanting visitation with their child/ren.

Profiles of Local Systems of Care

**for Children and Adolescents
with Severe Emotional Disturbances**

RICHLAND COUNTY, OHIO

**Prepared By:
Beth A. Stroul, M.Ed.**

**CASSP Technical Assistance Center
Center for Child Health & Mental Health Policy
Georgetown University Child Development Center**

**Funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)**

July 1992

INTRODUCTION

This case study was developed through a project conducted by the Child and Adolescent Service System Program (CASSP) Technical Assistance Center at Georgetown University. It is part of a descriptive study of local systems of care which was initiated in 1990 and funded by the National Institute of Mental Health (NIMH), Child and Adolescent Service System Program. The project has involved identifying and studying communities which have made substantial progress toward developing comprehensive, coordinated, community-based systems of care for children and adolescents who are severely emotionally disturbed and their families. Individual case studies of each local system of care are the products of this effort and are intended as technical assistance resources.

Systems of care for troubled children and adolescents have been of great interest over the last several years. In 1982, Knitzer estimated in her seminal study, Unclaimed Children, that of the three million children with serious emotional disturbances, two-thirds were receiving no treatment whatsoever and countless others were receiving inappropriately restrictive care because of the lack of community-based service alternatives. In 1986, Saxe conducted a study for the Office of Technology Assessment of the United States Congress which confirmed Knitzer's findings and stated that "Mental health problems are a source of suffering for children, difficulties for their families, and great loss for society. Though such problems are sometimes tragic, an even greater tragedy may be that we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available."

In response to these problems and to the growing number of calls for change, the National Institute of Mental Health launched the Child and Adolescent Service System Program (CASSP) in 1984 to assist states and communities in developing community-based systems of care for this underserved population. Through grants and technical assistance activities, CASSP has supported the development of interagency efforts to improve the services provided to the most troubled children and youth and their families. To provide a conceptual framework for system of care development, CASSP supported the publishing of A System of Care for Severely Emotionally Disturbed Children & Youth by Stroul and Friedman in 1986. This monograph has been called a blueprint for action in the child mental health field, and it describes the various service options required by these youngsters and the need for services across all of the relevant child-serving agencies. From these components, Stroul and Friedman proposed a design for a "system of care" encompassing both the full range of services and the mechanisms required for the assurance of their appropriate delivery. Currently, there is widespread agreement that community-based systems of care for youngsters who are severely emotionally disturbed and their families are needed, and the development of these systems has become a national goal.

Despite the calls for such systems of care, until recently there were few, if any, examples of local systems of care which combined an array of community-based services with other essential elements including interagency collaboration and case management. Today, there is what might be described as an explosion of activity related to system of care development. The activities of CASSP, which have now involved every state, have played a crucial role in stimulating system development at state and local levels. Increased attention to children's

mental health by advocacy groups also has had a major impact. Further, system building has been advanced significantly by initiatives such as the Robert Wood Johnson Foundation's Mental Health Services Program for Youth, which has provided funds for the development of systems of care in selected local areas, and extensive system development initiatives in a number of states. As a result, many communities now have evolving systems of care which can be studied and described. Descriptions of the system building approach and experience of these communities are designed to assist other communities which are attempting to develop such systems.

Potential sites for inclusion in this study were identified through a process of consultation with key informants including individuals at national and state levels who have extensive knowledge of developments in the children's mental health field and in the development of local systems of care in particular. Through these initial discussions, approximately 20 communities were identified. These localities were characterized as having made significant progress toward the development of community-based systems of care consistent with the philosophy and principles which have been promoted by CASSP and which are displayed on the following page. Accordingly, an attempt was made to locate local systems which are family focused, emphasize treatment in the least restrictive environment, involve multiple agencies, individualize services, and so forth. Similarly, an attempt was made to locate systems which have moved beyond the more traditional outpatient, inpatient, and residential treatment services and have begun to develop a more complete and balanced array of nonresidential and residential services including home-based services, day treatment, crisis services, therapeutic foster care, respite care, case management and others.

The second phase of the selection process involved extensive telephone interviews with a representative from each site to obtain detailed information about the array of services available in the community, the nature and functioning of the system level coordination mechanisms, and the nature and functioning of the client level coordination or case management mechanisms. In addition, information was collected about any special system activities related to such issues as financing the system, evaluating the system, involving families in planning and delivering services, and enhancing the cultural competence of the system of care. A chart was prepared for each potential site summarizing the service array, system level coordination mechanisms, and client level coordination mechanisms.

Selection of sites for further study was accomplished with the assistance of an advisory committee and was based on the following set of criteria:

1. Must have a range of services in place (home-based services, crisis services, therapeutic foster care, and others).
2. Must have interagency coordination mechanisms in place.
3. Must have client level coordination mechanisms in place, e.g., case management.
4. Must be a sufficiently well-developed local system to be able to serve as a useful example to the field and to receive national attention.

CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.
5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.
6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
10. Emotionally disturbed children should receive culturally competent services which are sensitive and responsive to cultural differences and special needs and are provided without regard to race, religion, national origin, sex, physical disability, or other characteristics.

5. Should have some noteworthy activities in one or more areas including family involvement, cultural competence, transition, high-risk children and adolescents, financing, and evaluation.

An initial group of five communities was selected for site visits by the project team. The site visits generally involved spending three to four days in each community engaged in a variety of activities designed to provide insight into the functioning of the system of care. These activities included interviews with a number of individuals and groups including key system managers, senior management representatives of the major child-serving agencies (mental health, child welfare, education, and juvenile justice), case managers, youngsters, parents, and advocates. Additionally, the schedules included visits to three or more service components in the system of care where activities were observed and discussions held with program managers, staff, and, in some cases, clients. An important aspect of the site visits was observing the functioning of interagency entities. Site visitors attended meetings of interagency entities focusing on system-level coordination as well as meetings of interagency teams organized for the purpose of creating individualized service plans for specific youngsters and their families. The site visits provided a wealth of information about each system of care -- its developmental milestones, strengths, and obstacles yet to be overcome.

The sample of communities studied yield valuable insights into the process of building systems of care. Due to an enormous increase in system development activities in communities across the nation, there currently are many more noteworthy examples of local systems of care. It should be emphasized that none of the communities selected for study have fully developed systems of care, and all are struggling to overcome financial and other obstacles to system development. Rather, they are communities which have succeeded in putting some basic building blocks into place and have demonstrated progress toward achieving system development goals. The resulting case studies are intended to serve as technical assistance resources for other states and communities as they approach the challenge of developing local systems of care for youngsters with severe emotional disturbances and their families.

REFERENCES

- Knitzer, J. (1982). Unclaimed Children. Washington, DC: Children's Defense Fund.
- Stroul, B. & Friedman, R. (1986). A System of Care for Severely Emotionally Disturbed Children & Youth. Washington DC: Georgetown University, CASSP Technical Assistance Center.
- United States Congress, Office of Technology Assessment. (1986). Children's Mental Health: Problems and Services - A Background Paper. Washington, DC: U.S. Government Printing Office.

PROFILE OF A SYSTEM OF CARE: RICHLAND COUNTY, OHIO

I. COMMUNITY CONTEXT

The system of care to be described serves children and families of Richland County, Ohio, situated in the north central region of the state. The county is chiefly identified as rural, but is located approximately midway between the cities of Cleveland and Columbus and is positioned along the major transportation routes between these two urban centers. As a result of its location, an urban influence on the character of the community is reported. The City of Mansfield, which is the county seat, is described as a small city which is a microcosm of Cleveland and Columbus.

The population of Richland County was 126,137 in 1990, a slight decrease from the 1980 population figure of 131,205. Approximately 40 percent of the county's populace resides in Mansfield, which had a population numbering 50,627 in 1990. The next largest population center is the city of Shelby with a population of 9,564. The remainder of the county consists of a series of small villages and communities spread over a 420-square-mile rural area.

Census data from 1980 indicate that the vast majority of the Richland County population is white, 91 percent. Approximately nine percent of the residents belong to minority groups, with most being African Americans. Much of the African American population is concentrated in Mansfield where the minority population is 19.8 percent. Less than one percent of the county's population is comprised of Native Americans, Asians, and Hispanics. During the growing season, the county experiences an influx of migrant workers whose needs must be considered. Additionally, a small group of Japanese families (currently numbering nine) reside in the county on five-year working visas primarily for managerial roles. Efforts have been made to accommodate these families, including organizing a Japanese Saturday School for youngsters in kindergarten through 12th grades at the Ohio State University Mansfield Campus.

Census data further indicate that the median family income in 1990 was \$35,600, and approximately seven percent of Richland County's families were below poverty level. For African American families residing in the county, poverty was much more pervasive with 26 percent falling below the poverty line. At that time, approximately one-third of the county's population was comprised of children and adolescents, age 18 or under, and there is some evidence that social and economic problems affect many of Richland County's children. Data cited in a recent application for an early intervention preschool program indicate that approximately 23 percent of Richland County's student population comes from families living in poverty, 22 percent were born out of wedlock, 16 percent were born to teenage mothers, and 13 percent receive public assistance.

The primary sources of income for Richland County are provided by a combination of industry and farming. For the past 50 years manufacturing dominated the county's economy. However, local industry was extremely hard hit by the recession of the late 1970s resulting in plant closings and general industrial decline. The closing of plants, such as Mansfield Tire in 1975, produced unemployment rates approaching 13 percent at the height of the recession.

The area has never completely recovered from this industrial decline, and more recently has suffered the loss of additional companies such as Ohio Brass, White Consolidated Industries - Westinghouse Division, Peabody Barnes, and Techform Industries which was based in Shelby. Other employers are reducing their workforces. As a result, the community continued to experience the net loss of a significant number of jobs in the 1980s.

Since 1975, Richland County has been involved in aggressive efforts to retrain displaced workers and to recruit new businesses to the area in order to rebuild its industrial base. A great deal of effort and collaboration among public and private sectors has been devoted to revitalizing the community's economy and to training and retraining the primarily blue collar workforce. Community leaders report that a great deal has been accomplished to offset previous losses.

Currently, Richland County is described as a community in transition, shifting to an economy based more upon service occupations and small businesses as well as manufacturing and agriculture. The largest current employers in the county include Chevrolet Pontiac Canada Division (General Motors), United Telephone Company of Ohio, and Empire Detroit Steel. Over 1500 farms operate in the county which yield crops, livestock, and associated products. In 1989, the unemployment rate for Richland County was 6.57 percent, a rate only slightly higher than the overall unemployment rate for Ohio. However, by August 1991 Richland County's unemployment rate had grown to 9.8 percent as compared with a 6 percent state unemployment rate, and Mansfield had the highest jobless rate among all Ohio's cities.

The climate of Richland County is characterized by four seasons and cold winters; temperatures are frequently below freezing from mid-November to mid-March. Promotional literature describes the county as the "last outpost of the Allegheny Mountain foothills," and two ski resorts are supported by the hilly terrain. Two state parks offer recreational opportunities to the community as well. Higher education opportunities are provided by the Mansfield Campus of Ohio State University and the North Central Technical College. These two institutions share a common campus and facilities. Ohio State University offers a variety of associate, bachelor's, and some graduate programs, while the Technical College offers associate degree programs.

The most frequently cited challenge facing Richland County is the need for economic redevelopment in the community. Rebuilding the county's economic vitality involves not only creating jobs and training displaced workers, but also educating and training young people for the employment market. Thus, jobs and job training are considered to be among the highest priority needs in the community.

Substance abuse is also cited by many people as a significant and widespread problem in the community, with the need for enhanced prevention as well as treatment activities for both youngsters and adults. Some agency executives indicated that problems facing the urban centers of Cleveland and Columbus often surface in Mansfield several years later. As a result, they anticipate an escalation of problems associated with drug abuse such as children of crack-addicted parents, AIDS babies, and the like. While these problems have not as yet been encountered in the community, it is recognized that planning for future social, health, and mental health services must anticipate these problems and consider needs for both treatment and placement resources.

A major strength of Richland County appears to be in the proactive attitude taken toward tackling problems facing the community coupled with a noteworthy history of collaboration among public and private agencies and organizations. Relevant agencies and groups have come together and designed initiatives to address problems including job training, economic development, substance abuse, educational reform, and early intervention as well as the needs of troubled children. This history of collaborative efforts to solve community problems has created an environment in Richland County that is uniquely suited to the development of a community-based system of care for emotionally disturbed youngsters and their families.

The human service system at the state level in Ohio consists of seven cabinet level departments including Departments of Mental Health, Mental Retardation/Developmental Disabilities, Youth Services, Human Services, Health, Education, and the recently created Department of Alcohol and Drug Addiction Services. While these agencies fund, regulate, and oversee local services, the service system in Ohio is largely county operated with community boards planning and directing service delivery in many of the categorical areas. Thus, the service system environment in Richland County is seen as one of local control and autonomy, with community level responsibility and decision making.

The following child-serving agencies and systems provide services in Richland County and are key players in the system of care:

- o Mental Health: Richland County Mental Health and Recovery Services Board and The Center for Individual and Family Services (The Center), a contract agency of the Mental Health Board
- o Child Welfare: Richland County Children Services Board
- o Education: Boards of Education in 13 School Districts and the Richland County Board of Education
- o Juvenile Justice: Richland County Juvenile Court and Ohio Department of Youth Services Regional Office
- o Health: Mansfield/Richland County Department of Health
- o Mental Retardation: Richland County Board of Mental Retardation and Developmental Disabilities

II. BACKGROUND AND HISTORY OF SYSTEM OF CARE DEVELOPMENT

History of System of Care

System building efforts on behalf of children and youth in Richland County date back to a series of meetings of human services representatives which were initiated in the mid-1970s by the newly elected Juvenile Court Judge. The meetings included any agency or organization involved in providing services to children and were used as a vehicle for sharing

information about each agency's role, responsibilities, and activities. The group became known as the Youth Services Coordinating Council (YSCC). Activities undertaken by the YSCC included a needs assessment and the compilation of a manual which described the services of each of the youth-serving agencies.

Another outgrowth of the YSCC was the successful application for a grant from the Law Enforcement Assistance Administration in 1981 to support the hiring of staff to manage and pursue efforts to coordinate services for children and families. The three-year grant established the Youth Resource Center and provided resources to support a director, assistant, and secretary. The Youth Resource Center grant was not actually implemented until 1983 due to a number of difficulties including the recruitment of qualified staff. In addition to the start-up delays, further operational problems were attributed to a yearly reduction in funding. By the third year, funds were available to support only a half-time position, and the scope of activities of the Resource Center was substantially reduced. During its brief tenure, the Youth Resource Center focused primarily on information sharing among agencies and coordinating multiagency staffings related to individual youngsters. Eventually the Youth Resource Center merged with another emerging group in Richland County, Community Action for Capable Youth (CACY), and remaining funds were transferred to CACY. As a result of the merger, the focus of activities shifted to substance abuse prevention and coordination activities which were, and currently remain, CACY's primary agenda. The Youth Resource Center was not considered an overwhelming success during its existence, but its concept and philosophy helped to lay the groundwork for contemporary system of care development.

The YSCC met over a period of years, typically on a quarterly basis. The group produced an agency directory and developed a model for multiagency staffings which called for the participation of all relevant youth-serving agencies in developing service plans and coordinating service provision to individual multineed children. While the YSCC continued to meet, there was considerable frustration related to its mission and role; many of its intended functions were not fulfilled. For example, the staffing model was never fully adopted by the participating agencies and was used only sporadically. Further, the directors of the key youth-serving agencies were not involved in the YSCC activities, indicating a tenuous commitment to the interagency process. By the mid-1980s, it became clear that the YSCC was floundering.

The system development process in Richland County was given a boost in 1984 when the Governor of Ohio signed an executive order mandating that each county establish a "cluster" of youth-serving agencies to coordinate and develop services for multineed youngsters. A group from Richland County attended a state-sponsored technical assistance meeting on cluster formation in Toledo and returned to the county ready to initiate this effort locally. Thus, the Richland County Interagency Cluster (initially referred to as the Interagency Linkage Group) was established in 1984 for the expressed purpose of developing, overseeing, and evaluating policies related to "the maintenance of interagency staffings of multineed youth."

One of the first products of the Cluster was the issuance of a joint policy statement on interagency staffings which was signed in September 1984 by 10 youth-serving agencies. The "Policy Statement on Multiagency Staffings" began by recognizing that a significant number

of youth have multiple and complex needs and that youth and families require the close and sustained cooperation of the agencies involved in providing services to them. The agencies which signed the policy statement pledged their firm commitment to such formal cooperation and to the provision of a "continuum of quality services" for multineed children and their families. Additionally, the policy statement declared the intent to provide services "as close to home as possible and in the least restrictive way."

The process designed during the early developmental phase of the Cluster involved the formation of small interagency staffing groups drawn together for a specified case. These multiagency staffings were not limited to the agencies signing the policy statement, but were envisioned as including representatives of all agencies involved with a particular child and family. Further, procedures were specified for developing a unified written service plan as the product of the staffing as well as selection of a primary case manager to assume responsibility for assuring that planned services were carried out and coordinated in an effective and timely manner. It was envisioned that the primary case manager would be a staff person from the custody holding agency if applicable or the professional worker in the agency providing the major care in each particular case. The steps outlined for the interagency staffing process included:

1. Problem Identification
2. Staffing Team Meeting
3. Sharing of Relevant Information
4. Determination of Primary Case Management Source
5. Identification of Strategies/Services and Preparation of Joint Service Plan
6. Progress Meetings
7. Evaluation of Service Delivery and Outcomes

A single release of information form also was devised to allow agencies to obtain consent from families for sharing necessary information among specified agencies in order to develop, implement, and monitor unified service plans.

With the formation of the Cluster, agency directors began to attend meetings somewhat more regularly. During its initial years, the Cluster focused almost exclusively on individual youngsters whose needs were not adequately being met with available community services. Cluster members recall that the first case they handled involved a child who was hearing impaired, severely emotionally disturbed, and developmentally disabled. Issues needing resolution involved custody, treatment, education, and more. This complex situation successfully brought many agencies together to consider the issues and to pursue solutions. The search for appropriate and effective options for this particular youngster eventually became a joint effort of the Richland County Cluster and the State Level Interagency Cluster.

Gradually, the Cluster began to focus on other children whose needs vastly exceeded local resources. The majority of the youngsters considered by the Cluster were candidates for out-of-county placement, and many were referred to the State Level Interagency Cluster in order to access state funds to share in the cost of these placements. In fact, during its early years of operation, the Richland County Cluster had an inordinately high rate of referrals to the State Level Cluster as compared with other counties. This high rate has been attributed, in

large part, to the lack of local treatment and placement resources. While this was not necessarily the intent, the early focus of the Richland County Cluster might be characterized as primarily arranging for and funding out-of-county placements.

By 1986, the Cluster had further formalized its role and decided to meet every other month at a fixed date and time. The logistics and support for Cluster activities were provided by a staff person from Richland County Children Services who assumed the role of coordinator in addition to his agency responsibilities. Participants report that the group was beginning to crystallize and function well together but that two preconditions for further system development were becoming increasingly obvious:

- o An essential condition for cluster functioning was the attendance, participation, and commitment of agency executives. It was characterized as exasperating for staff who attended cluster meetings to jointly develop a treatment plan for a youngster only to later find their agency unable or unwilling to commit to the plan or to support it financially.
- o There was a critical need for the Cluster to move beyond its focus on individual children and to shift the focus to system issues and to improving the system of care for children and families in Richland County. This recognition was directly related to the growing concern about the large outlay of funds going to support out-of-county residential placements with questionable long-term results coupled with a growing commitment to serve youngsters closer to home in the least restrictive environment. Cluster participants were becoming convinced that the development of community services could reduce reliance on out-of-county and out-of-home placements.

Several Cluster members were instrumental in moving the group from discussing the need to develop a system of care to taking action to pursue this goal. With the leadership of these individuals, the Cluster prepared applications for grants which would provide funds to begin the system building process in the county. One of the first grant applications requested state funds to support a program developer-consultant for community-based services to special needs populations. This program developer would help to design and implement missing service components, such as intensive home-based services, and make recommendations to the Cluster regarding further service development. Unfortunately, this grant was not funded, nor was a second grant application for similar purposes.

In 1988, a third grant opportunity became available, and, despite the disappointment of two previously unsuccessful applications, the Cluster decided to devote staff time to the preparation of yet another grant application for state funding. This request for applications called for the development of an entity to provide centralized intake services and case management services for multineed children and their families. This grant application was the only one selected for funding in the state; the centralized assessment and case management services were implemented in 1989 as an interagency project which became known as Gateway. An administrative board comprised of the executives of the major child-serving agencies was organized to cooperatively manage Gateway.

The Gateway grant was a major milestone in the development of Richland County's system of care and is said to have caused "cataclysmic" changes. Most obviously, the grant provided

much-needed resources to devote to local system development. However, the substantial impact of the grant can be attributed to a number of factors beyond funding. One reason for its momentous effect was the mandate that only chief executive officers of the key youth-serving agencies serve on the Gateway Administrative Board (which was similar in composition to the Cluster). Therefore, agency executives were compelled to personally participate in the system development process. This direct participation served to crystallize the executives' commitment to the system development goals and process; executives were required to provide local match, attend meetings regularly, and work directly with their counterparts to address system issues. A series of day-long retreats with an outside facilitator were held to develop the mission, goals, policies, and procedures for Gateway as well as for the Cluster and were instrumental in the process of the securing the "buy-in" and commitment of all key agency executives.

Another reason for Gateway's impact on the continued course of system development in Richland County was the grant requirement that a needs assessment for the overall system of care be conducted. The needs assessment led to clear directions and priorities for service development in the community, providing a map for the future. The needs assessment activities have led to the preparation of additional grant applications for resources to pursue the suggested directions. An example is the "Intensive Services Grant" for which the Cluster successfully made application to the State Level Cluster and received funding for a cluster coordinator, an intensive day treatment program, and an intensive home-based service program. These services were prioritized with the expectation that they would greatly reduce the number of youths placed outside the community and enhance the continuum of locally available services. Implementation of these services began in 1990.

Further, the task of developing Gateway as a cooperative, interagency service effectively shifted the orientation of the Cluster from nearly exclusive attention to staffing individual cases to a broader perspective which included consideration of policy and planning issues related to the overall system of care. As a result, the Gateway grant is credited with a major contribution toward moving the evolutionary process of Cluster development from an individual case focus to a system building focus. Documents produced in 1988 state that the Cluster felt compelled to "take a stand as a force for change" in local service delivery to multineed youth. The Cluster issued a new mission statement in 1989 to reflect this shift in orientation.

A letter from the Director of The Center for Individual and Family Services in support of the Gateway grant aptly reflects the role of Gateway in Richland County's system development process. "The Richland County Interagency Cluster has committed itself to develop a community-based system of care. While the commitment has been sincere, we have been hampered by a lack of resources to accomplish our objectives. The Cluster has, therefore, aggressively pursued several grants during the past year in order to implement the Richland County Plan. The grant preparation process [and the subsequent implementation of Gateway] has been an excellent experience for the Cluster. It has clarified our needs, solidified our plan, and strengthened the commitment of Cluster members to implement a comprehensive system of care."

In addition to the development of Gateway and other key service components, the mechanisms for system-level interagency coordination also have progressed in Richland

County. In 1990, the Gateway Administrative Board and the Richland County Interagency Cluster, which were nearly identical in composition, merged to form a single interagency entity. This entity officially adopted the structure of a council of governments (COG), becoming the Richland County Youth and Family Council of Governments. The COG structure allows the group to operate programs, apply for grants, hire staff, enter into contracts, and the like. The stated purpose of the COG is to "implement and coordinate the rendition of services for children and families throughout Richland County and to coordinate the rendition of services that are available for this purpose from various governmental and nonprofit organization." The COG also serves as the Interagency Cluster for Richland County.

State Influences on System of Care Development

While Ohio is characterized as a state with strong local control and responsibility for service provision, the state has had a significant influence on system of care development in Richland County and throughout Ohio. One area of clear influence has been the state's leadership in emphasizing and requiring interagency collaboration and coordination in service delivery, initiated during the administration of Governor Richard Celeste. In March 1984, Governor Celeste signed an executive order requiring interagency cooperation in service delivery to multineed children. The order established an Interdepartmental Cluster for Services to Youth at the state level, including the six state departments involved in serving children and adolescents. The order also directed county agencies to work cooperatively with other agencies in their respective districts, calling for the formation of local clusters to review specific cases of children with severe and multiple problems, develop individual service plans, and access existing or alternative programs and funding to meet the needs of these children. The agreement specified that children and adolescents could be referred to the State Interdepartmental Cluster after all attempts to resolve problems at the local level have failed. In 1987, the requirement for state and local clusters to coordinate services for multineed youth was codified in legislation. The mandate included a provision specifying the sharing of funding for planned services based upon appropriate agency involvement in each case.

It should be noted that collaborative efforts in Richland County preceded the state mandate for collaboration. For approximately 10 years prior to the executive order, Richland County had a locally conceived interagency entity established for coordination purposes. Nevertheless, the existing body had been faltering, and the executive order served to formalize the local commitment to collaboration and provide new incentive and purpose to the local collaborative effort.

The availability and awarding of grants to Richland County also have provided significant support to Richland County's system building efforts. Richland County was the only community in Ohio selected for the central intake and assessment project, and Gateway clearly has played a pivotal role in the development of the community's overall system of care. Fiscal year 1990 was the first year that a separate line item in the state budget was allocated to the State Interdepartmental Cluster. More than half of the available \$3.2 million was offered as "system of care grants" to local clusters in order to provide opportunities for communities to develop missing services. (The amount available in the fiscal year 1991 state budget was \$4.3 million.) The system of care or Intensive Services Grant awarded to Richland County has provided funds for a cluster coordinator as well as two service

components. Thus, the grant has provided resources enabling Richland County to expand the array of available community services as well as to support and refine the mechanisms used for system coordination. These grants, as well as other funding which has been available from the Ohio Department of Mental Health and other state level departments, have been predicated on collaboration among relevant agencies. In addition to providing much-needed start-up resources for system development, grants offered by the state have required interagency collaboration and reinforced its importance.

The state has further facilitated system development in Richland County by providing a series of training conferences regarding the role and functioning of clusters. Richland County representatives have participated in these events, and state staff have come to Richland County on numerous occasions to provide consultation and technical assistance. Additionally, the state provided funds for a consultant to work with Richland County in the implementation of its system of care. The consultant has played an important role in all phases of system building and his assistance is considered one of the critical factors in the success of Richland County's system building endeavors.

Another potential influence on system of care development is the Mental Health Act of 1988 passed by the Ohio legislature. This legislation, which became effective in fiscal year 1990, gives local mental health boards the responsibility for administering both inpatient and outpatient mental health funds. Boards are authorized to take a specified percentage of their allocation for inpatient care to utilize for alternatives to hospitalization. It was reported that Richland County is among 11 out of 53 counties which have opted out of this program due to their assessment of a potentially negative financial impact.

Very few instances were cited indicating ways in which the state has hindered system development in Richland County. Concerns were expressed about the seed money concept by which the state provides short-term grants to begin certain services or activities with decreasing levels of funding each year. Some of the grants provided to Richland County decrease substantially over a short period of time, making it extremely difficult for local agencies to absorb the costs. Many participants felt that it would be more realistic and facilitative if grants decreased more gradually and support were provided for longer durations, giving communities time to seek alternative funding sources, adjust their budget priorities, and the like.

On the whole, it appears that the state has had a significant influence on the course of system development in Richland County by encouraging interagency collaboration and by providing both financial and technical assistance to support system development.

III. PHILOSOPHY AND GOALS

While the Richland County philosophy had been evolving for some time, the retreats held in 1989 provided opportunities to further define the system of care philosophy and to reach agreement among the participating agencies. The retreats resulted in a mission statement as well as goals and objectives for the system of care. Based upon the mission statement and

discussions with key system participants, four distinct elements of the Richland County system's philosophy have been identified:

- o **Interagency Collaboration** - The system is based upon the premise that youth-serving agencies cannot operate in isolation or "run their own show." Rather, in order to provide effective services, agencies must collaborate with each other and share responsibility for developing, providing, funding, and overseeing service delivery. The belief in collective ownership of multineed children and their families appears to be strongly held and consistently expressed. Representatives of a wide variety of youth-serving agencies stated repeatedly that no one agency can do the job, that no one agency has ownership of a multineed child and family, and that there is a need for a coordinated network of services. This strong conviction in interagency collaboration permeates the system and has its roots in an impressive history of collaborative activities in Richland County around multineed children and in a variety of other areas.
- o **Keeping Youngsters in the Community** - Another element of the Richland County system's philosophy is the commitment to providing services in the least restrictive setting, to keeping youngsters within their homes and families whenever possible, and avoiding out-of-county placements to the greatest possible extent. In the early years of the Richland County Interagency Cluster, an average of 12 to 15 youngsters were in out-of-county placements at any given time. There was a growing recognition that the success rates of these expensive out-of-county placements were marginal, and the community sought alternative approaches for working with youngsters at risk for such placement. At the time of the site visit, only four children were in out-of-county placements. This reduction was attributed to the concerted effort to develop community-based treatment resources, coupled with the coordinated service delivery approach that has been adopted. This element of the philosophy evolved from economic as well as humanitarian concerns, in particular, the astronomical costs of serving youngsters in out-of-county placements. Today, there appears to be widespread agreement that treatment in the least restrictive setting and keeping youngsters within their homes and community is preferable on philosophical grounds, and efforts are devoted to this end.
- o **Family Focus** - A third element of the system philosophy holds that children cannot be isolated from their families and that the system of care must be committed to focusing on the entire family in the planning and delivery of services. Both agency executives and direct service workers talk about empowering families to reach their maximum potential and providing opportunities for families to succeed as units. Virtually all written documents related to the Richland County system consistently refer to "multineed children and their families." Further, all the new service components which have been developed in the community are family focused -- Gateway focuses on the problems, strengths, and needs of the entire family; Home-Based Services intervenes with the family unit in an attempt to avoid out-of-home placement; and Intensive Day Treatment has a parent component which involves providing services and support.

- o **Early Intervention** - A recurring theme in both documents and discussion is the need for early identification and intervention with multineed children and their families. In particular, the system is concerned with identifying children at risk for out-of-home placement and intervening earlier in the process to maximize the likelihood of successful outcomes. There are a number of early intervention activities ongoing in Richland County and the COG/Cluster is exploring ways to form more extensive linkages with these efforts.

The goals of Richland County's system of care parallel the elements of its philosophy and include the following:

- o To provide comprehensive, coordinated services to multineed youth and their families.
- o To provide services in the least restrictive setting and to keep children within their homes and community to the greatest possible extent.
- o To promote the involvement of families in the planning and delivery of services.
- o To promote early identification and intervention for multineed children and their families.

IV. TARGET POPULATION

The target population of the Richland County system of care is broadly defined as "children with multiple needs and their families." There has been a deliberate attempt to avoid establishing restrictive population definitions for the COG/Cluster or any of its programs. The rationale for adopting a broad, inclusive population definition is to reduce categorical thinking among agencies and to promote the concept of shared ownership of the population of youngsters with multiple needs and their families. The success of the current collaborative system development efforts in Richland County is attributed, in part, to the fact that responsibility for this population unambiguously rests with the COG/Cluster, and member agencies recognize and accept the need for joint programming, joint financing of services and supports, as well as mutual ownership of the target population.

A particular focus of the system is on children at risk for out-of-home placement, with a priority on those at risk for out-of-county placement. As noted, large amounts of mental health and children's services funds, as well as monies from juvenile justice and education, were being expended for out-of-county placements of questionable effectiveness. Thus, system building efforts have been directed at serving many of these youngsters in their own homes and/or communities to the extent possible.

The characteristics of segments of the target population have been described in various grant applications. In the Intensive Services Grant application, submitted in 1989, a profile was provided of the 33 youngsters considered by the Cluster since its inception in 1984. The youngsters brought to the Cluster have proven to be the most difficult to serve due to their complex and multiple needs and the inability of local agencies to meet their needs within

existing programs and services. These youngsters were predominantly male (nearly 80 percent) and predominantly white (nearly 80 percent). Their average age was just over 11, and more than three-quarters of these youngsters were described as having severe emotional or behavioral disturbances. The group indeed reflects youngsters with multiple needs as demonstrated by their involvement with multiple agencies. The youths had previous involvement with an average of 4.9 youth-serving systems and agencies including mental health, special education, children's services, juvenile court, health, mental retardation/developmental disabilities, rehabilitation, and residential facilities. Their histories substantiate high risk for out-of-home placements -- more than two-thirds had experienced an average of two out-of-home placements prior to Cluster referral.

Beyond the youngsters referred to the Cluster, the system of care is concerned with a broader population of youth with serious and multiple needs. For example, the Intensive Services Grant application states that in 1988 approximately 138 Richland County youths were placed in residential treatment facilities and group homes; 83 youths were seen at The Center for psychiatric evaluations reflecting a near two-fold increase from the previous year; and over 380 youths were seen by Juvenile Court and referred to community agencies for services. Additionally, a steady increase in the number of children and adolescents seen at The Center was reported. These data are presented as indicators of the need for improved services within the community.

Gateway, as a central component of the system, also carefully constructed its vision statement to establish inclusive target population guidelines and to ensure that Gateway's services are accessible to the entire system without restrictive eligibility criteria. Any child and family is eligible for Gateway's services, regardless of the referral source. Special care is taken to avoid any perception of excluding youngsters from Gateway's services. Gateway started providing services by having its Clinical Advisory Board select 25 of the most severely troubled, multineed children in the community who were not succeeding with the current level of services. These children and their families were then referred for Gateway's assessment and case management services. A strong argument for early intervention is provided by the fact that in each of these 25 initial cases, a teacher in the early grades had identified a problem which had not been adequately addressed. At the time of the site visit, attempts were underway to increase early intervention efforts through Gateway. As a result of these efforts, an early intervention specialist will be assigned to Gateway to conduct intakes and coordinate services to youngsters ages zero to five.

From its inception through September 1990, Gateway served 184 cases. Since Gateway serves those youngsters who have multiple needs and who are not succeeding with the current level of services from community agencies, this population reflects a substantial segment of the system's target population. This group was 63 percent male, 37 percent female, and its racial composition was approximately 79 percent white, 21 percent black. The majority of these youngster (more than 70 percent) come from families in which their natural parents are either divorced or never married. The largest referral sources include Juvenile Court, Children Services, Mansfield and Richland County School Systems, self referrals, and The Center. The most frequently identified problems among the Gateway population include school problems, behavioral problems, emotional problems, and parent-child problems.

One issue related to the target population is that, although the COG/Cluster is striving to reduce categorical thinking regarding children and their families, line workers in the youth-serving agencies may still be required to document eligibility for their particular services or funding. Systems of care must recognize and appreciate the "Catch 22" that may face line workers who may struggle with externally imposed eligibility requirements and other constraints.

V. ORGANIZATION OF THE SYSTEM

System Management

The organizing structure for the Richland County system of care is provided by the COG/Cluster. Within this framework all agencies participate in system management, and no single lead agency can be identified. While several agencies assume a more active, leadership role within the system of care, participants agreed that system management is a collaborative venture and that no one agency could be singled out as the "lead" agency. In fact, it was emphasized that there is little concern about which agency will own or manage services and a much more concentrated focus on building services that will enhance the system, with management issues seen as secondary.

The management approach adopted by the Richland County system was devised in 1990, in part as a result of the Intensive Services Grant (also referred to as the "system of care grant") from the State Level Cluster which provided funds for a cluster coordinator and for intensive services including day treatment and home-based services. This Intensive Services Grant is seen as a significant leap forward in developing an interagency collaborative system in the community since it clearly signified the intent of the Cluster to assume a principal role in system management functions. The grant proposal called for collaborative efforts such as management of the proposed day treatment program by the Cluster, a home-based services program implemented jointly by two agencies, and a system-wide process for quality assurance. This grant was said to reflect the willingness of Richland County community agencies to implement a fully integrated system of care.

The dilemma presented to Cluster members by the Intensive Services Grant was the lack of a legal entity or administrative structure for programs such as Intensive Day Treatment and Gateway. A committee was formed to explore potential approaches to organizing a structure to operate these programs as well as to coordinate the entire system. The committee considered entities such as a 501(c)(3) corporation. Based upon prior personal experience with a Council of Governments formed for another purpose, the group decided to research the applicability of the COG structure for the system of care. It was determined that Ohio's statutes governing COGs were advantageous, allowing the Richland County agencies to accomplish their objectives. The COG structure would allow for hiring staff, operating services, receiving grants, and the like -- all functions that the Cluster could not perform since it was not a legal entity. Thus, the COG was formed in 1990 and became the primary system management structure. The stated intent is to place additional services under the COG umbrella in the future.

The COG/Cluster has three officers -- President, President Elect, and Secretary/Treasurer. An Executive Committee is comprised of all COG members and includes the Executive Director of the Mental Health Board, the Executive Secretary of the Children Services Board, the Superintendent of the Mansfield City Schools, the Superintendent of the Richland County Schools, the Superintendent of the Mental Retardation/Developmental Disabilities Board, and the Health Commissioner. The Executive Committee plays a key system management role. In addition, the Cluster Coordinator plays a critical role in system management, serving as a tangible link between the planning and service delivery activities of all providers throughout the system. The role of the Cluster Coordinator includes administrative responsibility for Gateway, Intensive Day Treatment, and other programs to be operated by the COG/Cluster.

The Richland County Mental Health and Recovery Services Board plays a vital role within the system by serving as its fiscal agent. The Board "fronts" the money for system activities based on its cash reserves, and is then reimbursed when grants and other funds are received. By virtue of its fiscal agent role, the Board also performs some informal monitoring and auditing functions.

At the time of the site visit, the COG/Cluster was struggling with some of the administrative aspects of operating service delivery programs. For example, employees of COG programs were on the payrolls of a number of different agencies, with some on the payroll of The Center and others on the payroll of the Mental Health Board and the Mansfield City Schools, and were therefore governed by different personnel policies and under different benefit and retirement systems. To rectify this problem, the Richland County Board of Education was approached with the possibility of becoming the administrative agent for the system. The proposed scenario involved an agreement between the COG and the Richland County Schools to pay staff through the county school system and to handle all benefits and employment-related issues. This approach, allowing all staff to be employees of the COG and equalizing salaries and benefit packages among COG staff, was implemented as of January 1991.

Role of Participating Agencies

- o Mental Health: Richland County Mental Health and Recovery Services Board and The Center for Individual and Family Services (The Center).

The Richland County Mental Health and Recovery Services Board serves as the administrative and fiscal monitoring agent for mental health services in Richland County. The Board contracts with various provider agencies in the community for mental health and substance abuse services for adults and children. As noted above, the Mental Health Board plays an important role within the system of care by serving as fiscal agent for the COG/Cluster services including fronting funds to support program operations and performing informal monitoring and auditing functions.

One of the major contract agencies of the Mental Health Board is The Center for Individual and Family Services which is a large, multiservice community mental health center serving adults and children. The Center, in its current form, resulted from the 1975 merger of an existing community mental health center with a family service agency, and thus retains a strong child and family orientation. Despite this

orientation, resources for children's services remain relatively small. Like many mental health centers, resources are devoted in large measure to serving adults with severe mental illnesses. The Center has offices in Mansfield and Shelby, and provides a wide range of services including counseling for adults and children, mental health education services, medical/psychiatric services, emergency services, community support services, Big Brothers/Big Sisters, AIDS outreach services, forensic services, drug and alcohol services, and older adult services.

- o Child Welfare: Richland County Children Services Board

The Children Services Board provides a variety of child welfare services. The intake function involves the evaluation of complaints related to neglect, physical abuse, sexual abuse, emotional maltreatment, and dependency and determination of the need for services from community agencies. Through a contract with the Richland County Sheriff's Department, a full-time detective works with Children Services conducting investigations of sexual abuse allegations and following these cases through the judicial system. The agency's services also include protective services with ongoing supervision of families, foster care, and adoption services. Children Services operates a 23-bed residential facility (Down's Residence Hall) for children ages 8 to 18; behavior problems in home, school, and community are the primary reasons for admission. Additionally, Children Services operates two group homes and provides financial support for other residential placements for eligible youngsters when necessary.

The Children Services Board also plays a key role in the system of care. A Children Services staff person served as the Cluster Coordinator until the recent state grant enabled Richland County to hire staff to fulfill this role. Additionally, the current COG/Cluster chairperson is the Executive Secretary of the Children Services Board.

- o Education: Boards of Education of 13 Local School Districts and the Richland County Board of Education

Richland County contains 13 autonomous schools districts, each with its own board of education and superintendent. The largest of these districts is the Mansfield City Schools which provides a special education program for severely behaviorally handicapped youngsters in kindergarten through twelfth grades and serves a seven-county area for low incidence handicaps. The Mansfield City School System recently went through an extensive process to plan for the future of education in Mansfield. Two reports ("The Classroom of the Future" and "Spectrum 2000") have been issued which establish long-range educational plans for the city. The philosophy espoused by these plans, as well as by the Superintendent of the Mansfield City Schools, is that children must be served in the context of their families and that educational systems must be willing to collaborate with other agencies in order to provide effective services to families. The key elements of the plan include an emphasis on preschool/early childhood education, drug education, parenting skills education, after school care, special education, and a comprehensive high school which blends academic and vocational/technical programs.

In addition to the individual district boards, there is an elected county board of education with an appointed superintendent who oversees the Richland County Office of Education. The Richland County Board of Education does not directly operate schools but rather provides support and specialized programming including special education services to the 11 smaller school districts. The professional and auxiliary services provided by the Richland County Office of Education to the participating districts include a significant contribution to special education for all populations. In addition to providing four special education programs available to students from the local districts, the Office of Education provides special education consultants who visit local classrooms to evaluate students and instruction, implement changes in strategies, coordinate placements of handicapped students from local districts to county special education programs, and supervise and conduct in-service training for special education staff. The Office of Education also provides elementary and secondary consultants, talented and gifted coordinators, school psychologists, work-study coordinators, speech and language pathologists, and attendance counselors.

Both the Mansfield City Schools and Richland County Office of Education are active participants in the COG/Cluster.

- o Juvenile Justice: Richland County Juvenile Court and Ohio Department of Youth Services Regional Office

The Richland County Juvenile Court operates with an elected judge, a court administrator, and staff. The Juvenile Court provides a range of services including secure detention; foster care for unruly and delinquent youth; a restitution assistance program providing supervised employment with nonprofit agencies; "Save Our Students" which provides remedial tutoring for middle school youth facing failure; and in-home detention with intensive supervision which serves as an alternative to secure detention for appropriate youth. A specialized probation program provides a trained probation officer to conduct assessments to determine drug and alcohol dependence among involved youths. Referrals to appropriate treatment programs are made when indicated. Additionally, the Court contracts with The Center for psychological and psychiatric services including evaluations and groups for unruly adolescents and sex offenders. An agreement with Gateway provides the Juvenile Court with a Gateway assessment specialist for one day each week to conduct assessments on families at the Court. An interesting service offered by the Juvenile Court is the Parent Orientation - Mediation program which requires divorcing parents to attend a two-hour group educational experience about the potential effects of divorce on children and how to minimize the negative impact. Child custody mediation is available and is provided by training mental health professionals and attorneys.

The regional office of the Ohio Department of Youth Services provides funding for many of the Juvenile Court programs as well as monitoring local service delivery. The Department of Youth Services assumes custody of youthful offenders upon commitment by the Juvenile Court for felony level offenses, thereby transferring responsibility from the county to the state agency.

- o Health: Mansfield/Richland County Department of Health

The Department of Health provides a range of services to children and families in Richland County. Child and Family Health Services are funded by a block grant from the federal Bureau of Maternal and Child Health and include a range of components such as community planning, public health outreach, child health services including EPSDT screening, and perinatal services. The Health Department has a social worker on staff whose role involves identifying crises and adjustment problems among children and families and ensuring that they receive appropriate interventions. Close linkages are maintained with The Center, Gateway, Children Services, and other agencies for this purpose. A number of other programs serve youth and families including an early intervention project involving home visits to children at risk for developmental delays, and a program providing home visits to infants and families at risk of child abuse. Both of these programs involve home visiting by nurses; assessment of medical, social, and environmental conditions; and provision of educational and supportive services as well as efforts to access whatever resources are needed to respond to the situation. Both programs involve active follow-along components. Teen wellness, pregnancy prevention, and AIDS education programs also are provided.

The Richland Child and Family Health Services Consortium is an interagency entity which plays a significant role in planning and coordinating health services for children and families in the community. Its activities have included developing and conducting a Child and Family Health Services Community Needs Assessment and using the results as a foundation for planning. The consortium publishes a quarterly newsletter and sponsors an annual conference; the 1990 conference theme was "Parenting in the 90s."

- o Mental Retardation: Richland County Board of Mental Retardation and Developmental Disabilities

The Mental Retardation and Developmental Disabilities Board is responsible for planning and providing educational and training programs for mentally retarded and developmentally disabled children and adults. Services are offered beginning at birth and include evaluation, home visitation, parent counseling, case management, educational services, vocational services, and residential and respite care services. The Newhope School provides individualized educational programs and a range of supportive services to children and young adults ranging in age from 0 to 22, with components including an early intervention program and preschool as well as programs for school-age children. The Board operates four residential facilities serving severely and profoundly retarded children and adults as well as a foster care program serving both children and adults.

In addition to these major child-serving systems, a number of other agencies participate in the system by providing services to youth and families and through their involvement in the COG/Cluster. These agencies include:

- o Richland County Department of Human Services
- o City of Mansfield Human Resource Bureau
- o Richland County Private Industry Council
- o Bureau of Vocational Rehabilitation
- o Community Action for Capable Youth (CACY)

As in most communities, some agencies within the system assume a more proactive, leadership role in the organization and operation of the system of care. Other agencies are less active participants and assume a more peripheral role in system activities. While there is a constant effort to enhance the involvement and commitment of all agencies, there remains a core group of agencies which appear central to system management and service delivery, and which are prime movers in the system development process.

VI. SYSTEM OF CARE COMPONENTS

Outpatient Services

Outpatient services are provided by The Center for Individual and Family Services. A Coordinator of Children's Programs manages the outpatient services for children and adolescents which include individual, family, and group counseling. Approximately 10 to 12 therapists at the masters and doctoral level work with children and families, and two work exclusively in the children's area. A number of therapists at The Center have developed special expertise in areas including sexual abuse, play therapy, adolescence, adoption issues, separation/divorce, rage reduction, family systems, and others.

Consistent with the philosophy of The Center, an emphasis is placed on working with families whenever possible. Children and families may be seen for counseling once or twice a week, or more depending on the need and on the demands of the current caseload. While home visits are not always encouraged due to the loss of billable clinical time at The Center, therapists have the flexibility to visit children and families at home, schools, hospitals, court, and other locations if necessary. Staff are encouraged to use creative approaches in working with youngsters.

In addition to individual and family counseling, The Center offers a number of groups. These include self-esteem/social skills groups for children ages seven to nine, 10-week groups for adopted adolescents via contract with Children Services, groups for adolescents on probation via contract with Juvenile Court, "loss" groups in the schools for children who have lost parents, and a variety of parenting skills groups. An approach often taken by The Center is to respond to needs identified by other agencies. For example, the loss groups were the result of a need identified during The Center's annual meeting with school guidance counselors. The Center's STOP program consists of two staff persons who provide treatment, prevention, education, and interagency coordination around sexual abuse. Therapy groups, support groups, and other services are available to victims and offenders in child abuse situations as well as to family members. The Summer Youth Program, jointly operated by The Center and the Mansfield City Schools, involves groups for fifth and sixth graders who

are not succeeding in school. Group sessions focus on a range of emotional, family, and school adjustment issues; parenting sessions are offered to families.

Outpatient psychiatric services also are offered by The Center. A child psychiatrist works at The Center four hours weekly, and two of the three other staff psychiatrists will see adolescents. Psychiatric referrals are made for medication evaluations, psychiatric evaluations, and assessment of the need for hospitalization, homebound instruction, and the like. Unfortunately, the wait list for psychiatric evaluations at The Center may be as long as three months, with the exception of emergencies which are seen immediately.

The Center has felt the impact of the expansion of children's services within the Richland County system of care. At one time, The Center had a Coordinator of Children's Programs and three or more therapists who specialized in working with children and adolescents. Some of these staff persons have left The Center to fill positions at Gateway as well as in the new home-based service and day treatment programs; due to fiscal constraints, vacant positions have not been filled. Thus, The Center has suffered the loss of some of its specialized resources in the children's area, even though the overall system has profited. Due in part to staff shortages, the wait list at The Center for children and families is approximately four to six weeks and is considerably longer for psychiatric services.

Gateway

Gateway, a pivotal component in the Richland County system of care, is a centralized intake, assessment, and case management program serving multineed youngsters and their families. Two planning retreats were held in 1989 with representatives from numerous youth-serving agencies to define the vision and guiding principles for Gateway and to determine its role in the system. The resulting vision statement specifies that "Gateway is a central point of intake which will assist youth and their families in accessing appropriate human services and assist human service agencies to be responsive to each family's unique needs. Through customized, individualized service plans, Gateway will encourage families to utilize their strengths and advocate for needed services. Gateway will serve as a mechanism for cooperative agency activities." Thus, Gateway was designed as a focal point for assessing the needs of multiproblem children and their families, bringing together all needed community resources to meet the identified needs, and ensuring that the services provided by multiple agencies are coordinated. An Administrative Board comprised of the executives of the major youth-serving systems and a Clinical Advisory Board comprised of mid-level managers from the various systems were used to implement Gateway and design the service delivery process and procedures.

The initial phase of service delivery at Gateway is the assessment which entails gathering information from all involved agencies and holding a series of meetings with the child and family. The assessment focuses on all life domains and is designed to identify strengths as well as problem areas, to establish goals for the child and family, and to provide intervention options for the family to consider. If it is determined that additional Gateway services beyond the assessment are needed, case management services are then provided. Network meetings are an integral part of the Gateway case management approach. These network meetings bring together all agencies and professionals relevant to the specific case for the purpose of sharing information, clarifying roles and responsibilities, and developing a

comprehensive, coordinated intervention plan for the child and family. The family is considered an integral part of the team and, along with adolescents, attends and participates in network meetings. Gateway has some flexible funds that may be used to assist families in a number of creative ways including sending youngsters to camp, purchasing toys, or paying for an adolescent to attend the YWCA Teen Series. Under some circumstances, money may be used to meet an emergency need for a family, with the family making monthly payments to repay the "loan," interest free.

A major strength of Gateway is considered to be its neutrality, based upon its placement under the auspices of the COG. Since Gateway is not a part of any one agency, staff have the ability to push agencies to provide needed services and to network and coordinate with other agencies. Further, Gateway is in a unique position to identify system gaps and to plan for further system of care development, and is sanctioned by other agencies to play this role.

Home-Based Services

Home-based services were added to the array of services provided in Richland County as a result of the Intensive Services Grant received from the State Level Cluster. The program was jointly developed by The Center and Children Services Board, and the approach represents a melding of mental health and child welfare concepts of home-based interventions. Home-based workers are co-located, although one worker is employed by The Center and two others are employed by Children Services. Joint responsibility for the program is retained by the two agencies, with The Center and Children Services each implementing a component of the intensive home-based services. Both programs are directed at reducing the need for out-of-home placements.

Home-based services are geared to families with at least one member at imminent risk of removal from the home. Both Gateway and the Children Services feeder system are used as referral pathways for home-based services. The duration of services is approximately 8 to 12 weeks, with a somewhat longer duration for "mental health" cases. Workers carry caseloads of only two to three families at a given time in order to enable them to work actively and intensively with each family. The goal of both the mental health and Children Services components is to empower families and to connect them with the services and resources needed for ongoing support. Workers state that they will do "whatever it takes" to assist youngsters and families, an attitude characteristic of many home-based programs. Meeting basic family needs is considered an essential part of service delivery as well as building relationships and providing counseling. A grant from the City of Mansfield (approximately \$10,000 in Community Development Block Grant funds) provides flexible funds for home-based workers to use in a variety of creative ways to assist families.

Day Treatment

The Intensive Day Treatment Program is one of the services funded by the Intensive Services Grant received from the State Level Cluster. Implemented in 1990, the program serves youngsters ages 10 to 14 who are at high risk for placement outside the community. Eligibility criteria specified in the grant application target youth who are currently involved in the system, have not responded positively to existing interventions, are at risk for placement in a more restrictive facility, and have at least one parent or caretaker who is

willing to participate in the program. The program consists of two major components. The first is a full-day program which has a capacity of eight youngsters and includes a structured academic program, group therapy, structured recreation, medical screening, interpersonal skill building, and family participation. The second program component is an extended day program which operates 12 months per year and includes tutoring, group therapy, structured recreation, interpersonal skill building, and family participation. The extended day program serves 12 youngsters and operates from 2:30 PM to 7:30 PM during the school year and shifts to a full-day program when school is not in session.

The program is too new to have established its optimal length of stay. Consideration is currently being given to adopting 18 months as the standard length of stay in the program, with flexibility to adjust this based upon the needs of individual youngsters. The program attempts to focus an array of services on each youngster and family and to transition youngsters back to schools as soon as possible. Staff includes a program coordinator, special education teacher, aides, recreation therapists, and a mental health therapist. Parental involvement is emphasized by the program. Counseling for parents is available with the mental health therapist and a parent support group is held biweekly. Attendance at the parent group, which has a combination support and educational agenda, has been outstanding. Additionally, home visits may be conducted by the therapist when indicated.

The Intensive Day Treatment Program has important connections with a number of community agencies which play a significant role in service delivery. Gateway, for example, performs the assessments and prescreening of youngsters under consideration for admission to the Intensive Day Treatment Program. Richland County Special Education Consultants, employed by the County Board of Education, work extensively with the program and assist in designing and implementing its level system. Close working relationships are maintained with the schools, particularly in relation to youngsters' transitions into and out of the Intensive Day Treatment Program. Additionally, the program maintains close ties with The Center which provides ongoing consultation to the program coordinator and staff. Further, contributions of furniture, equipment, and services to the developing program have been made by many agencies.

Crisis Services

Crisis services are provided by The Center for Individual and Family Services. The central component of The Center's crisis response system is Helpline, a 24-hour telephone crisis service. Helpline responds to a wide range of crisis situations including those related to violence and abuse, drugs and alcohol, mental illness, emotional problems, and suicide. The primary services provided by Helpline are crisis counseling, information and referral, and some noncrisis counseling as well as services to the deaf community through a teletype system. Helpline is staffed by a core of full-time and part-time staff which is augmented by a cadre of volunteers. Volunteers receive more than 50 hours of formal training followed by an apprenticeship program and ongoing supervision. The program attempts to have both paid staff and volunteers covering the crisis telephone lines at all times and receives more than 2000 calls per month. It was estimated that approximately 40 percent of the crises handled are related to children.

Helpline plays a key role in the community service system in that it provides after hours crisis coverage for many community agencies. Rather than establishing separate 24-hour telephone capability at each individual agency, contracts with Helpline have been negotiated to provide coverage for Children Services, The Center's Drug and Alcohol Program, Newhope Respite Care (a Mental Retardation/Developmental Disabilities service), the Richland County Information Line, and others. As a result, Helpline maintains close linkages with a wide variety of community agencies and has access to approximately 11 back-up systems when services beyond telephone intervention are warranted.

A group of nine staff from The Center rotates to provide crisis back-up services. All have specific expertise in crisis intervention and handle situations involving both adults and children. Rather than providing mobile outreach services to clients' homes, staff tend to meet clients in crisis at the hospital emergency room when face-to-face crisis intervention is needed. Additionally, individual therapists may elect to provide their home telephone numbers to clients or may instruct Helpline to contact them directly if specified clients experience a crisis. A missing component of crisis services in the community is a crisis residential resource for children and adolescents. In some situations, short-term placement in emergency foster homes may be arranged. Some children in crisis are placed at the Attention (detention) Center for lack of other alternatives; a crisis stabilization unit of some type was identified as a needed future addition to the system of care.

Early Intervention

Early intervention is an area that has been emphasized in Richland County, and two major early identification and intervention programs are provided. The Richland County Early Intervention Program serves children with special needs from birth to age five. This program involves developmental screenings to identify children with a known or suspected handicap or signs of a delay in some area of development. To increase success in identifying children in need, free developmental screenings at the mall have been conducted on several occasions. Following an interdisciplinary assessment, the program offers classes for infants and toddlers and their families, support for parents, assistance for parents in locating needed community resources, and group and individual services. The range of services which can be provided include physical and occupational therapy, speech and language therapy, educational services, social services, supportive home services, individual and family counseling, audiological services, and parent training. The Early Intervention Program is a collaborative effort involving a number of county agencies including the Richland Newhope Center, Mansfield-Richland County Health Department, The Center, Department of Human Services, and Rehabilitation Service.

The second program is the Richland County Cooperative Preschool which was developed in 1990 through a collaborative effort of education and social service agencies. The program is funded primarily by a grant from the Ohio Department of Education to develop and operate an integrated early childhood "special needs, at-risk" program. The target population for the preschool includes children ages three to five who have been identified as being at risk of school failure because of a host of factors including family abuse and neglect, low socioeconomic level, handicapping conditions including emotional disorders, inadequate health conditions, inadequate educational readiness, family substance abuse, and others. It is estimated that approximately 25 percent of the children in the program have emotional

disorders, with some exhibiting extreme behavioral problems. In order to ensure a more normalized, integrated experience, half of the children admitted to the Cooperative Preschool are in the at risk/special needs category and half are not considered to be at risk.

The Cooperative Preschool is staffed by teachers, assistants, nurses, speech and occupational therapists, and a psychologist. An assessment specialist, obtained via contract with Gateway, also is included on the program staff. Multidisciplinary assessments are conducted to evaluate children and determine their needs as well as their potential eligibility for the Cooperative Preschool. In addition to the preschool classes and specialized services, the program includes extensive work with parents. Parents volunteer to assist in classrooms, and a newsletter, monthly parent education meetings, and a parent advisory committee are considered essential aspects of the program.

An approach to early intervention currently under consideration is the possible establishment of an integrated Child Development Center serving children from birth through age five. The building would be donated by the Mansfield City Schools and would allow for the co-location of a range of programs including the Early Intervention Program, Richland County Cooperative Preschool, Headstart, and early childhood programs offered by the YWCA and the Mansfield and Richland County school systems. A common assessment process is envisioned with subsequent placement of children in the appropriate early intervention or early childhood program.

Substance Abuse Services

Substance abuse services are provided by The Center. Outpatient counseling, service coordination, and education are offered to chemically abusing youth, adults, and their families. Approaches include individual counseling which focuses on chemical abuse treatment, family counseling which includes the significant people in the chemical user's life, and group counseling which provides education and support for living a chemically free life. An intensive outpatient program is available for youth, involving daily group counseling for up to six weeks. In addition to the substance abuse services offered by The Center, the system of care has access to two detoxification programs.

Community Action for Capable Youth (CACY) represents a unique component in the Richland County system of care. Founded by a group of parents in the late 1970s, CACY has primarily focused on issues related to substance abuse. The organization is described as a "community catalyst," bringing the schools, parents, and larger community together to address substance use and abuse among children. CACY is funded by the Richland County Commission, City of Mansfield, United Way, and donations; some of its workshops are sponsored by the Mental Health and Recovery Services Board. CACY's major emphasis revolves around providing and coordinating a wide variety of training activities and events on substance abuse for audiences including students in all schools, teachers, parents, law enforcement officers, professionals, churches, service clubs, and other community organizations. In addition to substance abuse prevention and education efforts, CACY, in collaboration with the Health Department and Planned Parenthood, recently started the Richland County Parenting Coalition to identify needs and coordinate parent training activities in the community.

Residential Services

Youngsters requiring treatment in residential settings have access to a number of placement options, several of which are located within Richland County. Richland County Children Services operates two group homes and a 23-bed residential treatment facility, Down's Residence Hall. Other residential treatment options used by the Richland County system include Parmadale Family Services located in Parma and Bellefaire in Cleveland.

Inpatient psychiatric services are available at Richland Hospital, a private hospital which has a specialized psychiatric unit serving children and adolescents with both mental health and substance abuse problems. Sagamore Hills, a state psychiatric hospital for children located in Cleveland, is available to residents of the Richland County area and serves a primarily pre-adolescent and adolescent population.

For adolescents, a separate mechanism for accessing and financing inpatient services was created when the Central Ohio Adolescent Center (a state psychiatric hospital in Columbus serving adolescents) was closed by the state in 1989. Ten mental health boards representing 16 counties joined together and formed a 501(c)(3) corporation entitled Alternative Care for Teens (ACT). ACT, and similar entities in other areas of Ohio, were given access to the money that had been used to fund the Central Ohio Adolescent Center to purchase inpatient care in private psychiatric hospitals in the community. ACT negotiated contracts with Richland Hospital, Harding Hospital in Columbus, Ohio State University Hospital, and Sagamore Hills to purchase inpatient services for adolescents. The original intent was that funds would be used to support alternatives to hospitalization as well as to finance inpatient services. However, participants reported that funding levels coupled with the increasing costs of hospitalization may limit the feasibility of diverting funds to such alternatives.

System Needs and Gaps

When the Intensive Services Grant application was prepared, it cited a marked lack of intensive treatment services within Richland County. In particular, the application noted few, if any, services which provided more than one to two hours per week of intervention and did not require out-of-home placement. Data presented in the application estimated that of the youngsters placed in residential programs by the Cluster, the needs of over half could have been met if intensive, community-based services had been available. Specifically, services such as day treatment, intensive home-based services, therapeutic foster care, crisis stabilization services, and respite care would reduce the need for placement in residential treatment and hospital facilities, many of which are out of county. The Intensive Services Grant allowed Richland County to fill some of these gaps by developing day treatment and home-based services. However, the need for additional intensive treatment options in Richland County remains.

The gaps in the Richland County system of care fall in both residential and nonresidential areas. There appears to be widespread agreement that the highest priority need within the system is for therapeutic foster care services. Despite the recent expansion of the system of care, the limited availability of beds in residential treatment programs within the county results in the placement of too many youngsters in residential programs outside of the community. The development of therapeutic foster care services in the county, as well as

additional options for residential treatment, would enable the system to meet these needs locally. Residential options for use in crisis situations, such as a crisis stabilization unit and emergency therapeutic foster homes, are also identified as a system need.

In the nonresidential area, the reported system needs include:

- o Day treatment for children ages 6 to 10 and for adolescents (the current Intensive Day Treatment Program serves youngsters ages 10 to 14)
- o Respite care
- o Transitional services for older adolescents
- o Additional case management services

The chart shown on the following page displays a plan for the Richland County system of care. It shows those services which are currently operating and those which are considered future possibilities. Among the high-priority future possibilities are therapeutic foster care, a crisis stabilization unit, and respite care. The availability of resources to support these services will determine when the system will implement these services.

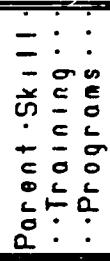
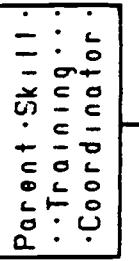
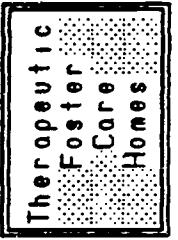
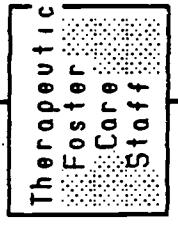
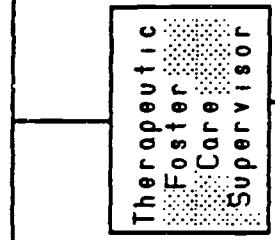
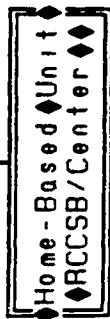
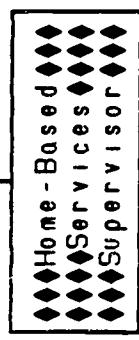
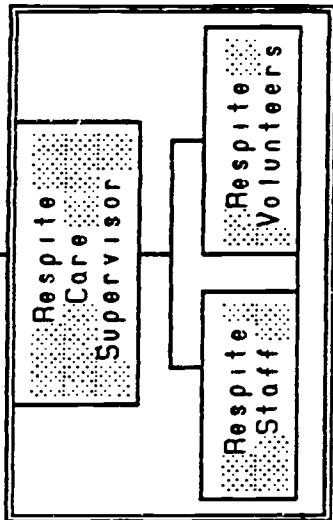
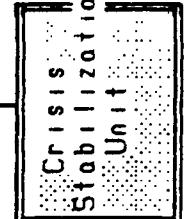
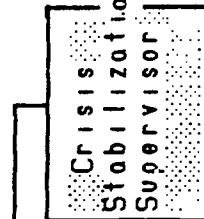
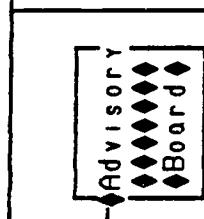
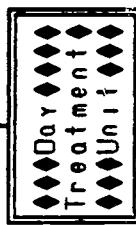
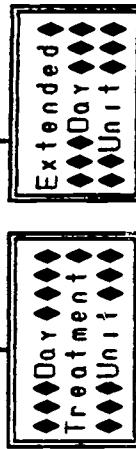
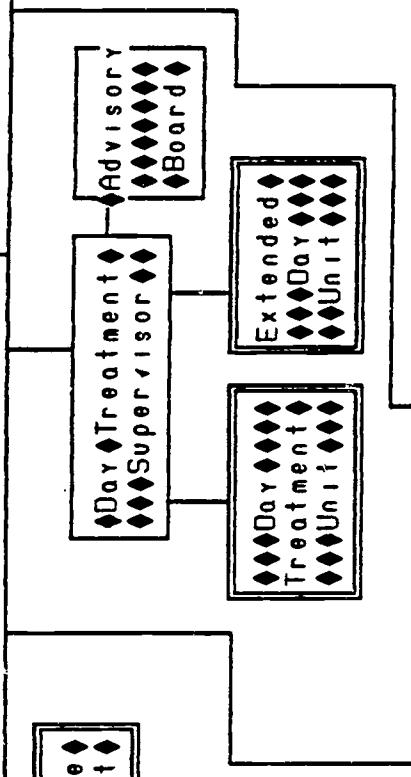
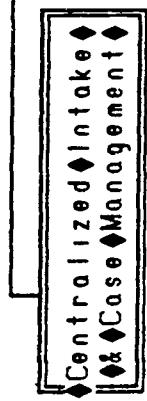
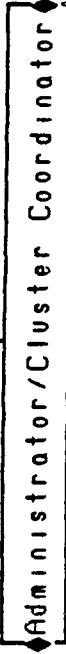
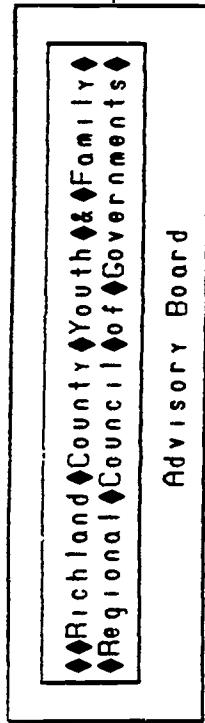
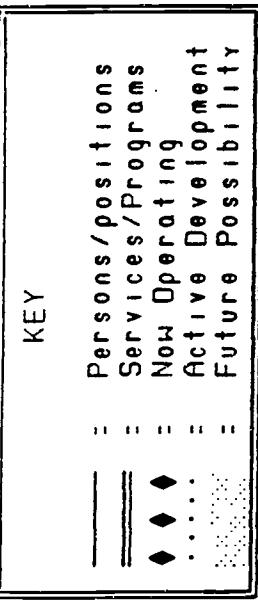
Another area of need noted during the site visit is to enhance the availability of services in Shelby and towns in outlying areas of the county. Most services and resources are concentrated in or near Mansfield, and families residing in rural areas may have difficulty in accessing these resources. For many families, transportation is difficult, and they may be forced to travel 25 miles or more in order to keep appointments.

VII. SYSTEM LEVEL COORDINATION MECHANISMS

Context for Interagency Collaboration

The interagency collaborative approach to the development of a system of care for troubled children is not without precedent in Richland County. In fact, there appears to be a history in the county of approaching problems through collaborative problem-solving strategies involving multiple agencies. Committees representing numerous agencies and organizations have been formed to address such diverse problems in the community as at-risk elementary age children, sexual abuse of children, early intervention, economic recovery, and others. Often, service development initiatives have emanated from these multiagency groups which have formed to address specific community problems. The Elementary School Children Coalition, Sexual Abuse Planning Group, Early Intervention Collaborative, and Parenting Coalition provide examples of the collaborative problem-solving approaches which are characteristic of Richland County.

- o Elementary School Children Coalition - This group formed to address problems related to elementary age school children who have been coming to the attention of the schools and community agencies. The symptom common to many of these children is excessive absenteeism, but they exhibit an array of additional problems which place them at risk. The Coalition considered potential service delivery approaches for this population and presented its recommendations to the Cluster in 1989. A committee



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Other Programs of Shared Interest

was formed to further examine the needs of this at-risk population and to recommend ways in which schools and community agencies could network to develop programs and share the costs of service delivery.

- o Sexual Abuse Planning Group - The rapidly growing problem of sexual abuse of children stimulated the formation of a multidisciplinary group to confront this issue. The group's membership included representatives of the medical community and mental health, child welfare, law enforcement, and judicial agencies as well as concerned private citizens. The result of this process was the development of a coordinated approach to handling sexual abuse cases in the community and for providing comprehensive treatment for child sexual abuse victims and their families. Children Services, The Center, the prosecutor and courts now work together to facilitate the legal process related to sexual abuse as well to facilitate treatment. The Center's STOP program is a tangible result of the collaborative planning process. The services provided by the STOP program include early identification; outreach; individual, group, and family counseling; specialized case management; and prevention and education programming. A comprehensive release form was developed to allow sharing of information among involved agencies and to simplify the intake process. The STOP program secured a full-time case manager who coordinates all services in an attempt to avoid the difficulties often encountered due to the involvement of multiple agencies in child sexual abuse situations.
- o Early Intervention Collaborative - This interagency group was formed to integrate the agencies which serve young children and their families in Richland County and to create an organized network for referrals and services. A wide range of agencies and programs are represented on the Early Intervention Collaborative including Headstart, the Mansfield-Richland County Health Department, Children Services, Newhope Center, Department of Human Services, The Center, Richland County Schools, Mansfield City Schools, and Shelby City Schools. Also represented are the Chamber of Commerce, Ohio State University-Mansfield, and the Northcentral Ohio Special Education Regional Resource Center. Two of the major activities of the collaborative have involved conducting a needs assessment regarding early intervention and the development of the Richland County Comprehensive Early Intervention Plan. While the collaborative officially formed in 1990, the Early Intervention Program was established in 1983 to identify and serve infants and young children who have developmental delays or are at risk. This program was designed based upon an interagency collaborative model, with an interagency advisory committee and a formal interagency agreement signed in 1988.
- o Parenting Coalition of Richland County - The Parenting Coalition was formed in 1990 under the leadership of CACY, the Health Department, and Planned Parenthood. It is a voluntary organization comprised of representatives of schools and community agencies which are involved in providing either education or services to parents. The purpose of the Parenting Coalition is to work cooperatively toward improving parenting skills in Richland County by providing a resource and support system. Specifically, the mission of the Coalition includes assessing the needs of parents, raising awareness of available services and educational opportunities, coordinating existing parenting education services, and sponsoring parent training programs.

As noted, a formal structure for interagency coordination with respect to multineed children dates back to the Youth Services Coordinating Council which was formed in the mid 1970s. Among the accomplishments of the YSCC was the development of a model for multiagency staffings involving all relevant youth serving agencies. Following Governor Celeste's executive order, the mechanism for system level coordination changed with the creation of the Richland County Interagency Cluster in 1984 for the purpose of ensuring interagency cooperation in providing a continuum of services for multineed children and their families. Originally called the Interagency Linkage Group, the Cluster's initial focus was on case planning and coordination for individual youngsters. The Cluster's focus gradually broadened to encompass planning for the development of a comprehensive system of care for children in Richland County. A number of grants were pursued by the Cluster in order to provide the resources to develop high-priority service components such as Gateway, Intensive Day Treatment, and home-based services.

Most recently, the structure for system level coordination evolved further with the formation of the Richland County Youth and Family Council of Governments for the purpose of implementing and coordinating services for children and families throughout Richland County. The COG, which also serves as Richland County's Cluster, is the mechanism currently used to coordinate the system of care and its component services.

Richland County Youth and Family Council of Governments

The Richland County COG/Cluster functions as an interagency structure for both system level coordination and case review purposes. The agreement creating the COG was signed in October 1990 by the Mansfield Board of Education, the Richland County Board of Education, the Richland County Children Services Board, the Mansfield/Richland County Board of Health, the Richland County Board of Mental Health and Recovery Services, and the Richland County Board of Mental Retardation/Developmental Disabilities. The purpose of the COG, as stated in the agreement, is to implement and coordinate the rendition of services for children and families throughout Richland County. Participants noted that Richland County was the first community in Ohio to formally organize its cluster as a COG, a legal entity which allows the agencies to act collectively for the purpose of operating programs, applying for grants, hiring staff, and other activities related to providing for the needs of Richland County children and families. The agreement confers the authority on the COG to:

1. Study problems which are of concern to two or more members of the Council as it shall deem appropriate including health, safety, welfare, and economic conditions as they impact on children and families.
2. Promote cooperative arrangements and coordinate actions among its members and between its members and other agencies of local and state government and the federal government.
3. Make recommendations for review and action to the members of the Council and, upon request, to other public agencies which perform functions similar to that of the Council in Richland County.

4. Promote cooperative agreements and contacts among the members, other governmental agencies, and private persons, corporations, and agencies.
5. Apply for and accept funds, grants, fees, gifts, and services from the United States or any of its agencies, the State of Ohio or any of its agencies, from political subdivisions whether a member of the Council or not, and from individuals and private corporations whether for profit or not for profit and apply the same to carry out the purposes of the Council.

As noted, the COG is governed by an executive committee comprised of the six COG members with three officers elected annually. An advisory board consists of all COG members plus the chief executive officers of a wide variety of governmental and nonprofit agencies serving children and families in Richland County, i.e., all Cluster members. This structure was based upon a legal opinion that only governmental entities which are taxing authorities and have their own boards could legally be part of the COG. The advisory board, created through COG by-laws, ensures that all other agencies become involved in the process and are not excluded from the interagency system building process.

COG activities are coordinated by the Cluster Coordinator, a position initially funded by the Intensive Services Grant from the State Level Cluster. Prior to this grant, the role of Cluster Coordinator was fulfilled by a staff person who held full-time responsibilities within the Children Services agency. In the grant application, it was stated that the Cluster had developed to the point where a coordinator was needed who could devote a significant amount of time to overseeing system coordination and planning activities. The role of the Cluster Coordinator was envisioned as encompassing several facets, focusing both on individual youngsters who may come to the attention of the COG/Cluster and on interagency coordination and service development efforts. At the time of site visit, the Cluster Coordinator was a newly established position, and the specific role of the Coordinator was evolving, particularly in view of the transition to the COG structure. As planned, the Coordinator fulfills a critical system coordination function, with responsibilities including:

- o Coordinating and handling logistical arrangements for COG/Cluster meetings and activities.
- o Maintaining information and tracking children and adolescents served by the COG/Cluster.
- o Maintaining contact with all system components and working with agencies and coalitions of agencies to develop shared programming.
- o Coordinating the activities of a Quality Assurance Committee representing all youth and family serving agencies which is attempting to standardize and coordinate quality assurance activities throughout the system.
- o Potentially serving as a screening point for all out-of-county placements and working with the community system to ensure that all possible county resources are utilized prior to bringing a child to the attention of the COG/Cluster.

- o Overseeing and coordinating service components operated by the COG.

It was felt that the Cluster Coordinator position would significantly speed the evolution of the system of care in Richland County, allowing the COG/Cluster to play a more active role in service planning and coordination.

COG/Cluster meetings occur monthly and are chaired by the current COG President and facilitated by the Cluster Coordinator. A typical meeting, which occurred in October 1990, addressed a number of agenda items ranging from individual cases to critical system planning and coordination issues. The portion of the meeting focusing on individual youngsters included updates on old cases, with discussion about progress and decisions about such matters as extending financial support for residential treatment for three additional months, planning a step-down placement for a youngster in residential treatment, and strategies to enhance parental involvement in a difficult case. Two new cases were presented to the COG/Cluster for consideration, both presenting challenging circumstances and multiple needs. In one case, that of a 15-year-old pregnant client diagnosed with manic depressive illness, the COG/Cluster members agreed to share the cost of a temporary supportive placement during the pregnancy while the client would be off medication. In the second case, the COG/Cluster agreed to purchase intensive home-based services from the Without Walls Program at Sagamore Hills Hospital, to seek MR/DD resources to provide training for the parents, and to possibly request assistance from the State Level Cluster.

These cases illustrate the functioning the COG/Cluster with respect to individual cases whereby children and families whose multiple needs have not been met within existing services are brought to the group for consideration. Cases brought before the COG/Cluster must first go through the assessment process at Gateway or, alternatively, Gateway staff must review the assessments done by other agencies and play a consultive role in the process. Often, COG/Cluster member agencies agree to share portions of the cost of purchasing needed services and supports for youngsters and families, typically based on whether the agency currently is or should be involved in the particular case. A rather unique disposition agreed upon in the context of the COG/Cluster was to share the costs of sending a child, his parents, and a mental health therapist from the Center for Individual and Family Services to a nine-day rage reduction therapy program in Colorado. This action was seen as an alternative to residential placement for the child. The mental health therapist reported on this experience at the COG/Cluster meeting and offered in-service training for other professionals in rage reduction techniques.

The remainder of the meeting focused on system level coordination and management issues. Both Gateway and Intensive Day Treatment, two services under the purview of the COG/Cluster, were considered in terms of programmatic and financial progress. A major problem area, that of a projected shortfall of \$55,000 in Fiscal Year 1991, was discussed at length. Participants felt that the step-down formula in the Gateway grant was too severe, and could more aptly be described as "leap down." Strategies to address this financial crisis were debated, and a decision was made to appeal to the state for additional funding as well as to increase local agency support for Gateway and other COG services. A one-day retreat was planned to focus exclusively on long-range financial planning for the system of care, with the specific objective of planning a more methodical approach to determining each agency's share of the local resources needed to continue to develop and support the system of care.

The retreat did, in fact, result in a number of decisions related to the financial crisis as well as future planning. Along with the adoption of cost containment measures, agencies contributed additional monies to remedy the shortfall in Fiscal Year 1991. Participating agencies reached agreement on their financial contributions for Fiscal Year 1992 and established four committees to continue the long-range planning process: Budget and Finance, Operations, Long-Range Planning, and Communications.

COG/Cluster members reported that the most difficult issue they have dealt with has been the fiscal viability of the system of care. While they have developed several critical components of the system, the uncertainty of continued state support and the availability of funds from local agencies to operate these services remained unanswered questions at the time of the site visit. The major priority of the COG/Cluster at that time was addressing the immediate financial crisis as well as the long-term financing of the system of care.

The functioning of the COG/Cluster was considered to be highly effective, though not problem free. Many participants emphasized the importance of personalities to the collaborative process, noting that agency administrators must be predisposed to the collaboration and must believe in the concept and philosophy of a coordinated, community-based system of care. It was suggested that the need for collaborative systems of care for children has obvious implications for the selection and training of administrators of child-serving agencies who can make a critical difference in the collaborative process. The leaders of the Richland County system repeatedly verbalized the need for coordination and appeared to view each service as one piece of an interconnected system.

Further, the Richland County agency executives reported that they depend on their strong personal relationships with each other for the resolution of the inevitable conflicts which arise. When conflicts occur, other players typically put pressure on the disagreeing members to resolve their differences. A delegation may even be used to meet with members to urge and facilitate compromise. Humor and friendly bantering play vital roles at COG/Cluster meetings in reducing tensions and nourishing the personal relationships among members.

Some agencies in a community are invariably reluctant to join into the collaborative process. The advice of the Richland County participants is to continue to attempt to involve reluctant agencies, but not to allow unwilling participants to slow the collaborative process down. Ways to involve hesitant agencies may include attempting pilots of various collaborative approaches on a small scale to encourage their participation and offering "carrots" such as opportunities for cost sharing. While attempting to involve these agencies, the collaborative system development process should proceed unchecked. The result may be that agencies which decline a meaningful role in system development and coordination may ultimately see the system developed and operated without their involvement, expertise, or benefit.

Confidentiality issues have not proven to be impediments for the Richland County COG/Cluster. A shared release form was developed, and a staff person from one of the involved agencies takes the lead in approaching parents to explain the interagency process and request that they sign the release. Rarely have parents refused permission for information sharing when they have been educated as to the purpose of the interagency process for service planning and coordination. COG/Cluster members, however, are cognizant of the need to protect sensitive client information. Case records are shared with COG/Cluster

members prior to a meeting to enable participants to familiarize themselves with the cases to be presented. Following the discussion, records and case summaries are placed in the center of the table, collected, and later shredded.

COG/Cluster members indicated that although some communities appear preoccupied with confidentiality issues, such issues need not prevent interagency collaboration. In some cases, confidentiality requirements may be used as an excuse for not working together. Participants indicated that the Richland County agencies are not stymied by fear of liability in this area and that legal and ethic requirements governing confidentiality can be met with few complications.

Joint Services

Joint services are another mechanism for ensuring system coordination, and Richland County has numerous examples of programs planned, administered, or operated cooperatively by multiple agencies. The most obvious examples of joint service delivery are provided by Gateway and Intensive Day Treatment which are administered by a collaborative group of agencies through the structure of the COG/Cluster. These programs are cooperatively managed and financed by the COG agencies.

In addition, a wide variety of agencies made contributions to these programs to assist with start-up needs such as financial contributions from the Richland County Juvenile Court and Mental Health Board, staff and computer software from The Center, furnishings and equipment from the Mansfield City and Richland County Schools, and more. Ongoing contributions by various community agencies to these programs are invaluable to their operation. For example, Richland Hospital provides staff to conduct group therapy and work with parents at Intensive Day Treatment.

A number of other programs represent the collaborative efforts of two or more agencies such as the STOP program, the Summer Youth Program, Home-Based Services, and the Early Intervention Program. These programs reflect a propensity in Richland County to address and solve problems by sharing resources and expertise in a coordinated manner.

VIII. CLIENT LEVEL COORDINATION MECHANISMS

The client level coordination function in the Richland County system of care is fulfilled to a great extent by the case management services provided by Gateway. Gateway focuses on multineed children and their families and uses an extensive assessment process to identify the child's and the family's strengths and needs, set goals, and define potential interventions. During the assessment phase, a determination is made as to whether Gateway case management services are needed.

Gateway employs three case managers, typically at the bachelor's degree level or below. Case managers carry caseloads of 15 to 20 active cases, a caseload which is considered appropriate for their style of case management. The Gateway case manager is seen as the central point

of information and coordination for the child and family. Similar to other case management services, the role of the Gateway case managers encompasses:

- o Helping the family to meet basic needs,
- o Planning services and interventions,
- o Locating or designing creative service alternatives,
- o Linking, brokering, and accessing services,
- o Coordinating and facilitating service delivery,
- o Monitoring services,
- o Advocating for the child and family, and
- o Educating and empowering the family.

Gateway case managers are guided by a well-articulated philosophy that emphasizes "empowering" families. This concept is defined as assisting families to select their own goals and priorities and further helping by providing information, teaching skills, giving families options for services and supports, allowing families to assume responsibility and make decisions, teaching families how to advocate for themselves, and instilling hope. Case managers made it clear that the family unit makes all final decisions about services.

A critical aspect of Gateway's case management approach is the "network meeting," which brings together all agencies and professionals who are or should be involved with the child and family. The family is considered part of the team, and the parents (and the youngster when appropriate) are essential participants in the network meeting. The goal of the network meeting is to obtain commitments from the various agencies for particular services and supports for the child and family. The initial network meeting is expected to result in a coordinated service plan, the "network plan," with clearly defined roles and responsibilities for all involved agencies and professionals. Follow-up network meetings for a particular child and family may be held if necessary, and, in particularly difficult cases, a series of network meetings may be needed in order to appropriately serve the child and family.

The network meeting is organized and chaired by the Gateway case manager. In addition to the primary agenda of planning and coordinating services for an individual youngster, the meetings are seen by Gateway staff as an educational opportunity. They allow case managers to educate all participants about the role of Gateway as a service planning and coordinating program rather than a treatment provider. Further, they continually attempt to convey the philosophy that no one agency can solve all problems, that responsibility for multiproblem youngsters and families must be shared, and that the network meetings are a strategy for accomplishing such interagency sharing and coordination. While agency executives have become committed to this philosophy, line staff are used to more categorical thinking. Often, they have had little experience of an interagency network and how it can function to benefit both the family and the system. Further, line staff may have had little exposure to the philosophy of family involvement and empowerment, and of making the system fit the family rather than making the family fit the system. As a result of participating in network meetings and in coordinated service plans, the line staff of other agencies and systems in Richland County are increasingly becoming more aligned with the philosophy espoused by Gateway and the system of care, particularly regarding the need for interagency collaboration and family focus in service delivery.

The Gateway case manager then monitors the implementation of the network plan, appraising service delivery as well as client progress. While Gateway case managers have no formal authority, they appear to have a good rapport with staff from community agencies and are able to prompt them to provide agreed-upon services when necessary. Some flexible funds are available to Gateway case managers to meet special needs. Case managers may use these funds for diverse needs such as paying an emergency bill, buying toys, taking a youth or family to lunch, or sending a child to camp. In some cases, families may make monthly payments to repay an outlay made by Gateway in response to a pressing need. The total amount of flexible funds available to Gateway case managers currently is \$2000. However, recommendations to increase the amount of flexible funds are under consideration.

Another task to be accomplished at the network meeting is the assignment of a "lead case manager" for each child and family from one of the involved service providing agencies. The lead case manager role is assigned to the agency or person who most logically could fulfill this role. There is no restriction on who might serve as lead case manager; in one case, the child's mother was assigned the lead case management role. The Gateway case manager, who typically works intensively with the family and involved agencies in the early phases of service delivery, may step back over time as service agencies and the lead case manager assume greater ongoing responsibility. Thus, over time the Gateway case management role shifts to one of monitoring and evaluating the service plan, contacting the family and lead case manager regularly to assess service delivery and progress, and determining if the network team needs to be reassembled for any reason. Gateway case management services typically are provided for a period of approximately six months or less, with the lead case manager and service providing agencies continuing to deliver services on an ongoing basis.

Using lead case managers from service providing agencies is an approach reportedly involving some challenges and complexities for the system of care. Through this approach, staff with varying backgrounds and skills may become lead case managers. While they may be experienced and skilled in their own fields, they most likely have not had any training specific to case management roles, skills, and activities. An additional responsibility for Gateway case managers often is to "train" staff from other agencies regarding the roles and responsibilities of case managers so that they can effectively assume the lead case management role. Beyond training, lead case managers may face time limitations and conflicting demands from other aspects of their jobs in their own agencies which may frustrate their efforts to adequately fulfill case management functions. In many cases, however, the lead case managers from service agencies are highly effective in monitoring and coordinating services for youngsters and families.

Thus, a combination of Gateway case management for multineed youngsters, network meetings, and the assignment of lead case managers from service agencies is used for client level coordination in the Richland County system. Given the extensive need for case management services, it was suggested that additional specialized case managers would be an important addition to the system. In particular, the system would benefit from case managers with the ability to work with youngsters and families for longer periods of time. These case managers might be added to Gateway or, alternatively, a case management component for children might be appropriately added to The Center, much like the case management component for adults with mental illness. Given the current fiscal constraints facing the system, there are no current plans to expand case management services.

Although it may not be feasible to hire additional case managers for the system of care, case management training is an area receiving attention. North Central Technical College offers a course in case management as part of its Human Services Program. Additionally, the Human Services Program has sufficient flexibility to allow a student to tailor an associate degree program in case management. Gateway staff have taken advantage of this opportunity. Staff from the system have taken advantage of training in case management offered by the Ohio Department of Mental Health over the past five years, including the First National Case Management Conference held in Cincinnati in 1990. Several respondents suggested that the COG might consider sponsoring case management training opportunities, particularly for staff who serve as lead case managers within the various service agencies.

IX. SYSTEM OF CARE ACTIVITIES

Family Involvement

A primary element of the Richland County system of care philosophy is that children cannot be isolated from their families and that the system must be committed to focusing on the entire family in the planning and delivery of services. This belief has been operationalized by ensuring that the family is a full participant in all phases of service delivery. First implemented by Gateway, families are included as essential participants in network meetings and all other efforts to develop and implement a service plan, and they are the primary decision makers throughout the service delivery process. Other agencies have embraced the philosophy of family involvement and family empowerment and have begun functioning in similar ways. Indeed, the rhetoric as well as practice in Richland County seem to indicate widespread acceptance of the importance of the involvement of families in service delivery. The new service components within the system are clearly family focused (such as Gateway and Home-Based Services) or have a family component (such as Intensive Day Treatment).

Despite the emphasis in family involvement at the service delivery level, Richland County has not as yet afforded families a meaningful role in policy making, planning, and administering services at the system level. Families and consumers are represented on the Richland County Mental Health Board, but are not yet included in any capacity on the COG/Cluster or other advisory committees related to the system of care for children.

Another gap is the lack of parent support or parent advocacy groups for children with emotional disorders in Richland County. The Northcentral Ohio Special Education Regional Resource Center is located in Mansfield and offers a series of parent training sessions on a variety of topics as well as support groups of parents of youngsters with various handicapping conditions. Few of these activities specifically address the concerns of parents of youngsters with emotional disorders, and there have been few attempts to stimulate the development of family support and/or advocacy groups for this population. Efforts to initiate an "Advocates for Invisible Children" group have met with limited success to date.

Cultural Competence

All participants in the Richland County system acknowledge the importance of creating a culturally competent system of care. However, it was also conceded that this is an area in which little progress has been achieved. Some actions have been taken toward reaching out to the minority community and enhancing both the accessibility and the cultural competence of services. For example, some agencies within the system actively attempt to recruit and hire minority staff. The Center attempted to place an outreach office in the Human Resource Bureau building which is located in an area accessible to the African American community in Mansfield. While this approach met with limited success, it indicated a desire on the part of the mental health system to improve its services to minority citizens in the county.

Gateway has had some success in reaching the minority community, with 20.7 percent of its clientele being minorities. This compares favorably with the percentage of minority clients on the caseloads of other agencies within the system. The improvement appears to be due to a location accessible to the minority community and efforts by Gateway staff to acquaint people in the minority community with their services. As an example, Gateway case managers visited African American churches to discussed Gateway services. In addition, acceptance of Gateway services in the minority community seemed to be enhanced following two successful episodes of services to minority families.

One agency within Richland County which has had considerable success in achieving cultural competence is the Human Resource Bureau. This agency works with a population comprised of 58 percent minority youth and provides a host of education, training, and employment programs. Among the strategies used to enhance cultural competence are:

- o Physical location accessible to the African American community.
- o Outreach to African American agencies, churches, and community organizations to educate people about services and recruit potential clients.
- o Recruiting and hiring African American staff.
- o Accommodating the needs of the client population by staying open until midnight, bringing medical personnel to the facility to perform required physicals, etc.
- o Including Black Ministerial Alliance and other key community groups in an advisory capacity.

The services of the Human Resource Bureau are described as client centered and are organized to facilitate the involvement of minority clients. Other agencies within the system may need to adopt similar strategies in order to reach and effectively serve the minority community. To date, little training in cultural competence has been available to staff in Richland County's child-serving agencies beyond a training event sponsored by the Ohio Department of Mental Health. It is recognized that improving the cultural competence of the system of care is a critical goal for Richland County.

Transition

The population of youth in transition to adulthood requires a constellation of specialized services in order to prepare them for independent living and for employment and to link them with needed services and supports within the adult service system. The Richland County

system of care includes several services that aid troubled youngsters in transition. First, the schools develop transition plans for older adolescents in special education, primarily focusing on vocational issues. Children Services offers a program for emancipated youth reaching the age of majority. Through this program, the agency may help to set the adolescent up on his or her own and provide a caseworker to offer support and instruction in independent living skills. Eligible youngsters are those in foster care or residential placements. Additionally, the YWCA offers a Home and Family Living Series which includes a series of sessions for a period of 10 to 12 weeks which can be followed by support groups.

While these programs offer some support to youth in transition, this clearly is an area in which the system must devote increased effort and attention. It was reported that linkages between the children's system of care and adult mental health system rest more on personal relationships than on formalized arrangements for ensuring appropriate transitions. For example, one of the Gateway case managers formerly worked as a case manager for adults at The Center and, by virtue of her ties with the staff, is able to involve youths in the adult mental health system on an individual case basis. More systematic provisions to link youth in transition are needed as well as more extensive programming to address the needs of this group.

Advocacy

The system of care for children in Richland County has developed despite the lack of organized advocacy activities on behalf of troubled children. There are no Mental Health Association or Alliance for the Mentally Ill chapters in Richland County, and no other advocacy groups focusing on emotionally disturbed children. Respondents indicated that the advocates for children in Richland County are workers within the system.

X. FINANCING

The primary strategies used to finance the system of care in Richland County include interagency funding of services on an individual case basis, interagency funding of system components, third party reimbursement, and local tax levies. Interagency funding of services for individual children is a strategy which originated when the cluster system was implemented in Ohio in 1984. The COG/Cluster considers cases of youngsters and their families with multiple and particularly challenging needs. If the COG/Cluster makes a decision to provide financial support for the service plan designed for a youth and family, an agreement is then reached among the participating agencies regarding their relative contributions. Often, it is the costs of an out-of-home placement that the agencies must share, but such arrangements may be designed for virtually any type of services or supports. At the time of the site visit, there was no set formula governing the participation of the various agencies in funding services. Typically, agencies contribute based upon their involvement with the particular youngster under consideration. For example, if the Mental Health Board, Children Services, and Juvenile Court are already involved with the youngster, they would most likely be the agencies which share the cost of the jointly developed service plan. There may be instances in which an agency assumes a share of the costs if the youngster should be involved or is eligible for that agency's services. In one case, the

Juvenile Court participated because the child had the potential to be a serious offender. A question under consideration by the COG/Cluster is whether an established formula should be developed to govern the percentage of financial participation of each agency in funding agreed-upon interagency service plans. In the interim, the agencies appear to achieve ready agreement regarding financial support for individual cases at COG/Cluster meetings.

Joint funding of service components is a second strategy employed successfully in Richland County to support system development. Gateway is a prime example of how funds from a variety of local agencies can be blended to develop and operate services considered central to the system's operation. In 1990, local agencies were providing 24 percent of Gateway's funding, local match for the Ohio Department of Mental Health grant. The largest contributors of local funds were the Mental Health Board and the Children Services Board; funds were also provided by the Mansfield City Schools, Richland County Schools, Juvenile Court, Mental Retardation/Developmental Disabilities Board, and Health Department. Part of the rationale for such blended funding is lies in the ability to reduce the use of residential placements by providing intensive, coordinated services. Savings to individual agencies resulting from reductions in residential placements can then be applied to additional community-based services. In addition to cash, agencies provide a wide variety of in-kind contributions to Gateway, Intensive Day Treatment, and others.

Due to the decreasing state grant funding mechanisms, it was anticipated that the local funding for Gateway and other system components would increase substantially by 1991 and further increase over the next several years. A major issue facing the COG/Cluster at the time of the site visit was the future financial viability of the newly developed service components and the extent of financial participation of each agency in supporting these services.

At the time of the site visit, third party reimbursement was not a major source of funds for the system of care. However, options for third party reimbursement were being explored with a view towards accessing fees, Medicaid, and other third party sources for services provided under the auspices of the COG/Cluster. There was some concern that COG/Cluster services would not be eligible for Medicaid reimbursement since they were not provided by a qualified mental health agency with psychiatric supervision. In addition, state barriers to Medicaid billing were a concern, in particular whether the COG was an eligible entity. As a result of considerable effort in working with the Ohio Department of Mental Health, these barriers have been overcome. As of July 1991, services provided by the COG/Cluster are eligible for Medicaid reimbursement.

Local tax levies provide a major source of funding for the operation of most of the agencies which participate in the system care. Levies for mental health, children's services, mental retardation/developmental disabilities, and others are held to provide local tax dollars to support service delivery. Each of the agencies relies upon levy funds to participate in interagency funding for individual youngsters and for service components such as Gateway. While no decision has yet been made, some respondents indicated that a tax levy may be the most consistent, secure mechanism for the long-term financing of COG services. Levies are burdensome and tend to be an unpopular funding strategy, particularly in an environment in which the public is reluctant to assume an additional tax burden. Nevertheless, the

COG/Cluster may consider an additional tax levy in mental health or another of the agencies in order to ensure sufficient funds for continued system development efforts.

At the time of the site visit, the Richland County system was grappling with a troublesome funding crisis. Of immediate concern, was a projected \$55,000 shortfall in the funds available to support Gateway's operation through the fiscal year ending June 30, 1991. This deficit was attributed to what was described as a drastic stepdown of state funding for this service. A portion of the October 1990 COG/Cluster meeting was devoted to discussion of this critical problem. A two-pronged strategy was devised -- approaching the state for additional funds to continue Gateway's operations and a more realistic stepdown formula as well as increasing local agencies' contributions.

Beyond the immediate funding crisis, the COG/Cluster members recognized the need to begin planning for the long-range fiscal viability of the Richland County system. Respondents noted that the system development process in Richland County has not been stymied by "fear of financing," as has occurred in many other communities. Rather, the agencies have created the system structure and basic service components, leaving the design of long-term financing strategies to a later stage of development. During the October 1990 COG/Cluster meeting, a retreat was planned in order to begin to address these financing issues. The major agenda item for the retreat was to be the development of a more methodical system for determining each agency's share of the funding for Gateway and other COG/Cluster services and designing strategies to ensure the long-term fiscal viability of the system. The retreat, held in December 1990, resulted in additional agency contributions to remedy the Fiscal Year 1991 shortfall as well as decisions regarding Fiscal Year 1992 contributions. Participants noted that if the COG/Cluster is committed to maintaining the existing services and to further development of the system, then member agencies must begin to build these costs into their budgeting processes in order to underwrite the future of the system of care. A finance committee was established in order to explore all potential funding options for the Richland County system of care.

XI. EVALUATION

Evaluation is an area that has lagged behind in the Richland County system. Few evaluation activities have been undertaken either with respect to individual components or the system of care as a whole. Participants report that when there is a choice between devoting time and energy to program development and direct service activities versus evaluation activities, program development and direct service always take precedence. While the importance of evaluation is recognized, it has not as yet occurred in any formalized or systematic manner. According to respondents, external pressure and perhaps specially targeted resources may be necessary incentives for serious attention to evaluation.

Despite the lack of attention to evaluation, there appears to be consensus as to some of the measures that might be used to assess the effectiveness of the system of care. These include:

- o Increased number of children served,
- o Increased number of children maintained in their own homes,

- o Reduction in money spent on out-of-county placements,
- o Effectiveness of individual service components, and
- o Younger average age of children served (earlier intervention).

One crude measure of progress may be provided by considering the number of referrals from Richland County to the State Level Cluster. This provides a rough estimate of the number of youngsters whose needs could not be met locally through the collaborative efforts of the Richland County agencies. In 1986, Richland County referred 22 youngsters to the State Level Cluster for consideration; by 1990 referrals to the State Cluster were reduced to three. This has been attributed to the new community-based services developed locally as well as to the interagency effort to create and fund services and supports needed by youngsters and families.

Quality assurance is an area that the system is beginning to address. A plan has been developed to establish a system-wide Quality Assurance Committee which will function under the auspices of the COG/Cluster. The Committee will conduct case reviews and develop standardized quality assurance requirements for the entire system of care. The initial focus of the Quality Assurance Committee will be on COG services.

Another role planned for the Quality Assurance Committee is to identify youngsters in out-of-county placements and assess the likelihood of success in these placements as well as the feasibility of bringing these youngsters back to Richland County for services. It is expected that the Quality Assurance Committee will be a vehicle enabling Richland County to begin to think in terms of system outcomes rather than individual agency or provider outcomes.

While there are no cross-agency management information or tracking systems, Gateway has developed a tracking system for children and families. Additionally, aspects of Gateway services have been assessed based on samples of cases served by the centralized intake, assessment, and case management agency. For example, a sample of 20 randomly selected cases was used to assess the success of the referrals made by Gateway. It was found that families referred to Gateway were already involved with an average of about two agencies or services; Gateway assessments took approximately 22 days; the average number of identified needs per family was about 4; the average number of referrals per family was 2.7; and the average number of case management hours per family was nearly 12. Of the 57 referrals made for the sample of 20 families, 59 percent were considered successful, 8.5 percent inappropriate, 26.2 percent delayed, and 7 percent incomplete.

In addition to these efforts at Gateway, the Richland County system participated in an evaluation sponsored by the State Interdepartmental Cluster for Services to Youth. The evaluation, conducted by the Ohio State University College of Social Work, assessed the system of care development efforts of 11 counties in Ohio which have been recipients of grants from the State Level Cluster. The evaluation consisted of site visits to Richland County and the other participating counties and involved gathering a blend of qualitative and quantitative data reflecting system development. The evaluation was designed to focus on the service delivery level and the system level, i.e., clusters. Areas assessed relative to service delivery included impact of the local system on children and families served, satisfaction of children and families, characteristics of children and families served, and performance indicators such as number of out-of-home placements and number of referrals

to the State Level Cluster. At the system level, evaluators assessed the effectiveness of the county cluster by examining degree of collaboration and commitment, current and future financial commitments, probability of the project continuing after funding ends, barriers to implementation, and strengths and weaknesses of the cluster. While not specific to Richland County, the evaluators reached a number of general conclusions regarding the system of care development efforts in the 11 funded counties. They determined that system development efforts did, in fact, result in the following benefits:

- o Increased collaboration and intersystem communication.
- o Increased flexibility and creativity in programming to serve multineed children and their families.
- o Expanded community-based services allowing communities to reduce their reliance on out-of-home and ~~out~~-of-county placements.
- o Increased use of less restrictive placements.
- o Increased involvement of systems which have traditionally operated separately such as education.
- o Increased use of individualized case planning approaches and involving families in the service planning process.
- o Increased availability of prevention and early intervention services.
- o Enhanced community investment, particularly financial, in maintaining the system of care.

XII. MAJOR STRENGTHS AND CHALLENGES

Through interviews with key informants representing a wide variety of constituencies involved in the Richland County system of care, a number of factors which are critical to the success of the system were identified. The major strengths of the Richland County system include the following:

- o **Leadership** - By far the most frequently noted strength of the Richland County system lies in its leadership. Initially, system development efforts appear to need a core group of two to three individuals who are willing to devote a great deal of time and energy to initiating collaborative activities and convincing others as to the potential benefits of collaborative system building efforts. A core group of active leaders was instrumental in the early stages of system building and continues to be evident in Richland County.

It was repeatedly emphasized by many respondents that the close involvement of the agency executives of the key child-serving agencies in planning, developing, and operating the system is critical to its success. Most contend that communities will have difficulty achieving system development goals if agency executives are not directly involved in the interagency process and if they are not willing to put aside differences, share resources, and work toward common goals. Thus, the involvement and commitment of agency executives and their willingness to collaborate are crucial. In Richland County, agency executives meet regularly through the COG/Cluster structure and appear uniformly committed to pursuing collaborative strategies in

order to achieve common system development goals. It is their leadership, clear sense of mission, values, and modeling of collaborative behavior that sets the tone for staff at all levels of the system.

Respondents noted that the longevity of the key players in Richland County may have some positive effect on the system building process. A number of the agency executives have been in their current positions for some time or have held other positions within Richland County. As a result, they have a history of working through problems with each other and are intimately familiar with the structure and politics of the system. Respondents speculate that continuity of leadership may be an asset, and that it might be difficult to pursue the system building agenda with significant turnover among the leadership.

- o **Shared Responsibility and Vision** - Another strength is in the clear acceptance of mutual responsibility for the target population of youngsters and families among the agencies participating in the system of care. There appears to be a pervasive belief at the highest levels of the system operation that troubled children and their families are the shared concern and responsibility of all involved agencies, that no one agency can meet the needs in isolation, and that joint funding and programming are essential. Perhaps of even greater importance is the common vision shared by the agencies involved in Richland County's system. The mission and goals of the system were developed at a retreat with the assistance of an outside facilitator. The jointly developed mission and goals provide a clear sense of purpose and guide system development efforts. It appears that the explicit acknowledgement of shared responsibility and the shared "big picture" or vision for system development among agencies comprise an important strength in Richland County.
- o **Proactive Attitude** - Apparent in this and other initiatives in Richland County is a proactive attitude toward problem solving. When a problem is identified, it often is seen as a challenge to devise creative and collaborative solutions. Respondents noted that people in Richland County have not been stymied by obstacles presented by funding sources or lack thereof, by political forces, or by seemingly overwhelming economic and social problems. Rather, they tend to take action and proceed to attempt to develop viable solutions. Rather than asking "Can we do that?", Richland County players ask "How can we do that and pay for it?" This willingness or ability to "jump in with both feet" and to take a proactive approach toward collaboration and system development is a clear strength. Several of the agency executives have even taken risks within their own systems, for example by redirecting funds to collaborative services such as Gateway. This spirit of determined dedication among the leadership has enabled the community to move beyond planning to actual system implementation and to piece together the resources needed to accomplish this.
- o **Meaningful Interagency Process** - The COG/Cluster process that has evolved in Richland County is meaningful, a process which deliberates critical issues and has tangible and significant outcomes. Collaborative processes are doomed to failure if participants feel that they are attending just another meeting and that the impact of their efforts is likely to be negligible. In Richland County, participants in the COG/Cluster typically feel that it is a vital collaborative process which focuses on

issues of grave importance to children and families in the community and which potentially could create dramatic system improvements. Motivation to attend and to participate is most certainly enhanced by ensuring that the collaborative process is a meaningful one.

- o **Team Approach to Problem Solving** - A number of respondents noted that Richland County leaders tend to use a team approach to problem solving. Whatever the issue may be, they generally are willing to sit down and hammer it out until it is resolved, even if this involves confrontation. Turf issues surface no matter how well functioning a system may be. However, it appears that the Richland County system is able to move beyond turf issues in many instances in order to negotiate and develop solutions to the pressing operational and financing problems facing the system. Retreats have been used effectively in Richland County to create a structure for problem solving, and outside facilitators also have proven valuable in helping the leadership to reach consensus at critical junctures in system development.
- o **Service Implementation** - The ability to move from planning to the actual implementation of several service components is seen as a strength of the Richland County system. The Gateway grant, a pivotal milestone in the system's development, provided the opportunity to accomplish something concrete. The development and successful operation of Gateway, in turn, has created considerable momentum and motivation to continue the system building process and to create additional components such as Intensive Day Treatment, Home-Based Services, and others. A number of respondents indicated that it may be essential for communities to have an opportunity to start putting their system of care plans into action by actually implementing service components.
- o **Size of Community** - Richland County is a relatively small community. A number of respondents indicated that the small size of the community is an asset to system development efforts in a number of respects. In a smaller community, the number of involved agencies is manageable, individuals from the various agencies are familiar with each other, and lines of communication are fairly easy to maintain. Further, agency directors tend to be in closer touch with clinical realities and service delivery problems than they might be in larger communities. Thus, the size of the community may be a factor that has contributed to the success of system building efforts in Richland County.

While the Richland County system embodies a number of noteworthy strengths, it also faces a number of challenges or problems which must be overcome in order to ensure continued development of a coordinated, community-based system of care. These include:

- o **Long-Term Financing** - The lack of a long-term financing plan for the Richland County system of care is undoubtedly the largest challenge looming in its future. State grants and a patchwork of local match have provided the primary means to begin the system development process, allowing the development of Gateway, Day Treatment, and Home-Based Services as well as the hiring of a Cluster Coordinator. On a short-term basis, these grants have had a powerful impact on the system by enabling the community to begin to implement service components fairly quickly.

These grants, which provide decreasing levels of funding over their lifetime, must be completely replaced by other funding streams within several years, a relatively short period of time. Without efforts to secure a long-term stable funding base for these programs, their viability is in question as well as the community's ability to continue its efforts by putting additional components into place.

The financing plan for the system of care will have to include a number of elements including both public and private funds. Participants recognize that local agencies will be forced to contribute increasing shares of the costs of the system of care from their own budgets, invariably necessitating redirecting funds from other functions or services. The boards of the participant agencies must be educated more fully as to the importance of the system of care and must be prepared to take on increasing shares of system costs. The need for a full-time grant writer to apply for any available sources of support is recognized as well as the need to maximize opportunities for third party reimbursement for services. Funding problems are complicated by what is described as inflexible state regulations around funding and reimbursement for services. For example, there are stringent time limitations on funding for residential treatment with little or no ability to adjust this based on an individual child's needs and restrictive rules governing reimbursement for case management. Regardless of the difficulties inherent in tackling this issue, the viability of the entire Richland County system is threatened by the lack of secure, long-term financing for system of care services.

- o **Human Resource Needs** - Another critical challenge facing the Richland County system relates to the need for qualified staff to provide services within the system of care. The need to consider and address the human resource implications of system development is becoming increasingly apparent. For example, The Center had a cadre of trained clinicians specializing in working with children and adolescents. A number of these therapists left The Center in order to develop and staff some of the new service components. Due to fiscal constraints, The Center has been unable to fill the vacant positions resulting in a loss of competent children's mental health staff at The Center. Thus, while the system of care has gained, there have been adverse implications for The Center and for its ability to provide services to children. While demand for services is increasing, The Center is left with fewer staff members with specialized skills in working with children and adolescents. It was reported that some agencies are offering incentives to staff to keep them from leaving for other jobs within the system. Thus, it is clear that along with plans for service development, Richland County must consider plans to meet its human resource needs including recruiting, hiring, training, and retaining staff with expertise in community-based service approaches for youngsters and families.
- o **Training of Line Staff** - While agency leadership has "bought into" the philosophy and collaborative approach to service delivery, the philosophy and approach have not yet filtered down to all line staff throughout the system. Respondents identified the need for additional in-service training opportunities for line staff in all child-serving agencies to convey the mission and goals of the system of care as well as information on the purpose and functioning of Gateway, network meetings, case management, home-based services, and so forth. The collaborative philosophy and process cannot

totally succeed until it has permeated all layers of the system. It was reported that staff become committed to this approach after they have experienced a network meeting organized by Gateway or have had the opportunity to be involved in a collaborative planning and service delivery episode around a particular youngster and family. Participation in the process helps to instill a sense of confidence about the potential inherent in this approach as well as the potential for helping staff to do their own jobs more effectively. While first hand experience is undoubtedly the best education, training opportunities both within individual agencies and across agencies are necessary to convey new attitudes, plans, and procedures for the system of care and to overcome mistrust and old patterns of turf protection.

- o **Service Gaps** - Richland County has made remarkable progress in developing services within a relatively short period of time. Nevertheless, a number of significant service gaps still exist in the community. As noted, needed services include therapeutic foster care, crisis stabilization resources, day treatment for additional age groups, respite care, transitional services for older adolescents, and additional case management services. A substantial challenge facing the community is to identify and access the resources needed to develop these services.
- o **Community Education and Involvement** - In addition to educating staff throughout the system, another identified challenge relates to educating both the lay and professional communities in Richland County about the needs of troubled children and their families and about the evolving system of care. Respondents indicated that the public is essentially uninformed and uninvolved and does not understand what services are available or why the system of care is important to the community. Similarly, efforts to involve the community in the care of troubled children through the use of mentors, volunteers, Big Brothers and Sisters and the like also are scarce. Lack of community awareness and involvement is considered a potentially serious flaw for the system of care, and extensive and assertive efforts are needed to foster understanding and support for system building efforts.
- o **Reluctant Agencies** - No matter how well developed a system may be, there remains the potential for agencies to be reluctant to participate in system activities. Resistant, or simply less committed, agencies can prove to be a frustration for those agencies which have dedicated themselves to an interagency collaborative approach to system development and operation. Richland County has several agencies which are less enthusiastic participants in the system. While system building activities have not been delayed, continued efforts to involve all child-serving agencies in the system are needed.
- o **Parent Involvement** - The entire system of care is based on a strong philosophy of serving families and of involving families in planning and delivering services. A challenge for the Richland County system is to take this philosophy even further and involve parents more fully in system-level policy making and planning activities. Efforts also are needed to stimulate the development of parent support groups as there currently are few opportunities for mutual support among parents of youngsters with emotional disorders. The need to improve the capacity for parent advocacy is yet

another important challenge. Parent advocacy could be crucial to the future growth of the system of care.

- o **Cultural Competence** - Modest efforts have been devoted to reaching out to the minority community and to enhancing the cultural competence of services. Cultural competence is recognized as an area needing increased attention within the system of care, and much remains to be done to better meet the needs of minority children and families in Richland County.

Despite these challenges, progress toward developing a comprehensive, coordinated, system of care for troubled children and their families in Richland County has been impressive. Respondents emphasized several strategies which have been particularly helpful in advancing the pace of system development in the community. First, obtaining the direct participation and involvement of agency executives has been critical to Richland County's progress. Second, the use of an outside facilitator with strong mediation skills has helped the participants to work through difficult tasks and problems. A skilled facilitator can assist a group to remain focused on long-range system planning issues and to avoid being stalled by an exclusive focus on the day-to-day crises that invariably confront the system. Third, the use of periodic retreats offers an opportunity for busy administrators to concentrate without interruption on the challenges facing the system of care and on designing strategies to address them. Retreats have been used to reach consensus on the mission and goals of the system as well as to respond to the financial crisis and to the need to begin developing a long-range financing plan.

Finally, respondents emphasized that interagency collaboration and system development are evolutionary processes which cannot happen overnight. Team building in interagency groups such as the COG/Cluster takes an enormous investment of time and energy and goes through various stages of development. Involving agency executives, and using facilitators, retreats, and the like can speed the process and progress of such efforts. Nevertheless, system building efforts take time, patience, and nurturance.

XIII. TECHNICAL ASSISTANCE RESOURCES

Richland County has been involved in providing technical assistance to other communities which are interested in developing systems of care. The consultation provided has taken several forms including telephone consultation, presentations and workshops at conferences, and on-site visits to the community to observe the functioning of Gateway, the COG/Cluster, and other aspects of the system. Participants are in the process of preparing a "replication manual" which will summarize the steps taken to develop the Richland County system. This document will be available in 1992.

THE RICHLAND COUNTY YOUTH AND FAMILY REGIONAL COUNCIL OF GOVERNMENTS' VISION STATEMENT

A family serving system should be based on proactive intervention and empowering families to reach their maximum potential. The C.O.G. reflects the desire to provide opportunities for families to succeed as units.

The C.O.G. will assist youth and their families in accessing appropriate human services and assist human service agencies to be responsive to each family's unique needs.

Through customized/individualized service plans, the C.O.G. will encourage families to utilize their strengths and advocate for needed services.

The C.O.G. will serve as a mechanism for cooperative agency activities.

THE RICHLAND COUNTY YOUTH AND FAMILY REGIONAL COUNCIL OF GOVERNMENTS'

GUIDING PRINCIPLES

The C.O.G. will help families to increase their self esteem and maximize their potential through the assistance of a coordinated human service system.

The C.O.G. will promote and maintain excellent relations with all community care providers at both the administrative and care delivery level.

The C.O.G. will provide leadership in facilitating change in the community care system to assist families in obtaining the services needed to create a functional unit.

The C.O.G. believes that each child and family in Richland County deserves to have access to coordinated assessment and treatment services of high quality.

The C.O.G. will effectively and efficiently use available resources creatively.

COMPETENT, caring people will be the guiding force behind decisions made for the C.O.G.'s activities.

The C.O.G. will treat every individual and family with respect and dignity.

AGREEMENT
CREATING THE
RICHLAND COUNTY YOUTH AND FAMILY REGIONAL COUNCIL OF GOVERNMENTS

Pursuant to the provisions of Chapter 167, Ohio Revised Code, the Boards of the public units named in Article I hereby agree to the formation of a Youth and Family Regional Council of Governments for the purpose of providing assistance to the residents of Richland County concerning social problems affecting children and families. Each of the Boards named in Article I will designate one (1) representative for all purposes of the Council of Governments.

ARTICLE I ORGANIZATION

THAT the Richland County Youth and Family Regional Council of Governments shall be composed as follows:

1. The Mansfield City Board of Education.
2. The Richland County Board of Education.
3. The Richland County Children Services Board.
4. The Mansfield/Richland County Board of Health.
5. The Richland County Board of Mental Health and Recovery Services.
6. The Richland County Board of Mental Retardation/Developmental Disabilities.

ARTICLE II PURPOSE

It is the purpose of the Richland County Youth and Family Regional Council of Governments to implement and coordinate the rendition of services for children and families throughout Richland County and to coordinate the rendition of services that are available for this purpose from various governmental and nonprofit organizations.

In carrying out this purpose the Council shall have the authority to:

1. Study problems which are of concern to two or more members of the Council as it shall deem appropriate including health, safety, welfare and economic conditions as they impact upon children and families.
2. Promote cooperative arrangements and coordinate actions among its members and between its members and other agencies of local and state government and the federal government.
3. Make recommendations for review and action to the members of the council and, upon request, to other public agencies which perform functions similar to that of the Council in Richland County.
4. Promote cooperative agreements and contracts among the members, other governmental agencies and private persons, corporations and agencies.
5. Apply for and accept funds, grants, fees, gifts and services from the United States or any of its agencies, the State of Ohio or any of its agencies, from political subdivisions whether a member of the Council or not, and from individuals and private corporations whether for profit or not for profit and apply the same to carry out the purposes of the Council.

ARTICLE III FISCAL MANAGEMENT

The Council shall appoint its own fiscal agent from its members in accordance with the procedures provided by law for the receipt and disbursement of public funds, receive, invest, expend and account for all money of the Council. Each Board listed in Article I shall annually appropriate from the funds available, money to operate the Council, but no member shall be required to appropriate any funds unless available to the Council under Article II, Paragraph 5.

ARTICLE IV CONTRACTING

The Council shall have the authority to contract with the appropriate

officials, authorities, boards or bodies of any political subdivision or non-profit agency including those which are a member of this Council and to receive from or provide to such appropriate official, authority, boards or bodies any service within the scope of this agreement which the bodies have the authority to render.

ARTICLE V MEMBERSHIP

Any member shall be permitted to terminate its membership upon sixty (60) days written notice to the Council of the action of its board to terminate its membership. Upon the termination from membership of any member, the Council shall recommend to the remaining subdivisions any amendment needed to this agreement in order to continue to carry out the functions of the Council.

ARTICLE VI EMPLOYEES

The Council may employ or contract with other organizations for the services of such persons as it shall deem necessary to carry out its duties, shall set their compensation and benefits and may terminate their employment without cause at any time. The Council may also purchase or lease such supplies, equipment, materials and facilities as are necessary to carry out its functions. It may accept any gift, bequest, devise, grant, services or payment and determine the appropriate expenditure of all money available to it in order to carry out the purpose of this agreement.

ARTICLE VII BY-LAWS

The Council shall by a majority vote adopt By-Laws for its operation including officers and other organizational matters which shall govern all aspects thereof. Such By-Laws may be amended from time to time by a majority vote of the Council, but no By-Law shall be inconsistent with the provisions of this agreement or in excess of the authority granted by Chapter 167, Revised Code.

ARTICLE VIII AMENDMENT

This agreement may be amended from time to time by the action of a majority of the boards who compose the same.

IN WITNESS WHEREOF, this agreement has been approved by the legislative bodies of the respective parties on the date indicated below.

BOARD OF EDUCATION, MANSFIELD CITY
SCHOOL DISTRICT PURSUANT TO A
RESOLUTION ADOPTED _____, 1990

Met Coleman, Superintendent

BOARD OF EDUCATION, RICHLAND COUNTY
SCHOOL DISTRICT PURSUANT TO A
RESOLUTION ADOPTED _____, 1990

David C. Cardwell, Superintendent

RICHLAND COUNTY CHILDREN SERVICES BOARD
PURSUANT TO A RESOLUTION ADOPTED
_____, 1990

Gerald Futty, Executive Secretary

MANSFIELD/RICHLAND COUNTY BOARDS OF
HEALTH PURSUANT TO A RESOLUTION
ADOPTED _____, 1990

Thomas Blum, Commissioner

RICHLAND COUNTY BOARD OF MENTAL HEALTH
AND RECOVERY SERVICES PURSUANT TO A
RESOLUTION ADOPTED _____, 1990

William Wood, Director

RICHLAND COUNTY BOARD OF MENTAL RETARDATION/
DEVELOPMENTAL DISABILITIES PURSUANT TO A
RESOLUTION ADOPTED _____, 1990

Connie Ament, Superintendent

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RICHLAND COUNTY INTERAGENCY
CLUSTER FOR SERVICES TO YOUTH

MISSION STATEMENT

The Richland County Interagency Cluster acknowledges that public and private child-serving agencies face two major service delivery problems in dealing with multineed children and their families. First, a number of families have difficulties that require them to be involved simultaneously with several agencies. Despite each agency's efforts to produce streamlined formal service plans and to cooperate with other agencies' efforts, there is no formal way to insure that coordinated comprehensive multi-agency service packages are developed and delivered with a minimum of accessing demands to the families. Services to help multi-problem families run the risks of being redundant, overlooking important treatment issues, being delivered only after problems have reached crisis proportions or being delivered in such a way that the family becomes exhausted and discouraged with a host of appointment times, history takings, diagnostic procedures and treatment sessions. This situation becomes more apparent as the number and complexity of the family's presenting problems increases.

A second service delivery problem is the presence of gaps in the array of needed services. Service provision to children and their families is carried out by a number of agencies, each with its own legal mandate and its unique sphere of operation. It has become clear that gaps do exist in the continuum of services that we aspire to. In part, this is because no single body is available to carry out a general evaluation of services to multineed children and their families in Richland County and either make recommendations for program development or implement its own programs to improve the overall service delivery picture.

In light of this situation, the goal of the Richland County Interagency Cluster for Services to Youth is to promote the coordination of human services to multineed youth and their families. The Local Cluster will take steps to insure that a comprehensive continuum of services is made available to multineed youth and their families with a minimum of duplication, as early as possible in the child's life, in the child's own home wherever possible and with a minimum of service access demands upon the family.

In order to accomplish this goal, the Local Cluster will conduct and keep minutes of bi-monthly meetings of those agencies mandated by H.B. 304 to be involved in Interagency Cluster activities. Other agencies and persons will be invited to attend those meetings as is deemed appropriate by the above mandated agencies.

The Local Cluster will review cases of multineed children whose service needs exceed local service capabilities and/or financial resources. Based upon a review of such cases, the Cluster will develop when necessary a formal written unified service plan that will identify the role of each agency in serving this child/family. If necessary, the Local Cluster will refer the case to the State Interdepartmental Cluster for Service to Youth for additional service recommendations and/or participation in the funding of special services. The Local Cluster will monitor the progress of the cases it accepts and will correspond with the State Cluster regarding these cases when appropriate.

The Local Cluster will play a leading role in developing and maintaining a process for the early identification of children with multiple needs who are potentially at-risk of out-of-home placement. In order to accomplish this objective, the Local Cluster will both develop policies and procedures for reviewing such cases

and developing unified service plans and also either allocate existing funds or seek new funding to support this process.

Finally, the Local Cluster will devise a procedure for evaluating community services to multi-need youth and promoting enhancements to or additions to existing services. The Local Cluster will establish a body of direct service specialists to research the needs of multi problemed youth and their families. It is envisioned that the Local Cluster will be actively involved in the creation of new services to such youth and to the augmenting of existing services and will seek funding for such services.

This Mission Statement was approved by the Richland County Interagency Cluster at a special meeting held on 01/10/89.

GAF/dsw
Typed 01/11/89

AUTHORIZATION FOR RELEASE OF INFORMATION TO INTER-AGENCY CLUSTER

____ IS HEREBY GRANTED PERMISSION TO RELEASE TO
____ such information as may be judged necessary
to obtain professional services for the benefit of _____
DOB: _____

PURPOSE FOR DISCLOSURE: To secure appropriate information from the above-named person or organization to assist in treatment planning for the client.

Release of the following information is hereby granted: _____

Witness _____

Signature of person authorized to consent

Title _____

Relationship _____

Head of Office releasing information _____

Address _____

Date _____

Date _____

Length of time of release _____

Agencies of the Inter-Agency Cluster:

The Center for Individual and Family Services
Richland County Dept. of Human Services
Richland County Children's Services
Richland County Health Department
Richland County Mental Health Board
State Interdepartmental Cluster
Human Resource Bureau

Richland County Juvenile Court
Mansfield City Schools
Richland County Board of MR/DD
Richland Count Schools
Rehab. Services of NCO
Gateway

NOTE: All matters relating to the physical or mental condition of the above-named client are considered privileged and confidential and are treated as such by the above agencies. Information cannot be given without the consent of the parent, client, or guardian, or re-released without the written consent of the client or his/her guardian (See Ohio Revised Code 2317.02).

I have the right to revoke this release of information at any time. Although I understand that I cannot do anything about information I previously said could be shared, I now want no more information shared and am withholding consent, effective per the date appearing below.

Date _____

Signature of person authorized to consent

3:00
1/1/00

GATEWAY

A Central Intake & Assessment Alternative

165 West Third Street
Mansfield, Ohio 44902
(419) 522-8777

AUTHORIZATION FOR RELEASE OF INFORMATION

GATEWAY

(Name of agency, hospital, institution)

is hereby granted my permission

to: (circle one) release to / receive from / release to and receive from:

(Full name and address of person, institution or agency)

such information as may be necessary regarding the services for:

(Print or type full name of client)

(Date of Birth)

Purpose or need for information:

Specific information to be released:

This consent expires on:

(Specify date, event or condition)

This consent to disclose may be revoked by me at any time except to the extent that action has already been taken. This authorization for release will automatically expire 90 days after the date on the release, unless otherwise indicated.

NOTE: As required by Section 2.32
(a) Prohibition on Rediscovery
of patients and/or persons being
identified as an individual who
abused alcohol or drugs. This
information has been disclosed
to you from the records whose
confidentiality is protected by
Federal Law. Federal Regulations
(42 CFR Part 2) prohibits you from
making any further disclosures of it
without the specific written consent
of the person to whom it pertains, or
as otherwise permitted by such
regulations. A general authorization
for release of medical or other
information is not sufficient for
this purpose.

(Signature of client)

(Signature of parent or guardian)

(Relationship)

(Date signed)

(Witness)

GATEWAY
CASE MANAGER JOB DESCRIPTION

JOB RESPONSIBILITIES: Under direction, provides direct client and family contact in their natural environment; serves as client advocate, acting in client's best interest at all times; provides support to clients and their families through education and referrals; analyzes and recommends new program development; assists client and family to find appropriate treatment and services and monitors continued appropriateness of these services.

QUALIFICATIONS: Associate degree or equivalent experience in human services related field plus one (1) year mental health related experience or experience and training which evidences an advanced knowledge of training and or case management; ability to obtain an Ohio driver's license.

DUTIES:

1. Acts as liaison with parents/guardians, community agencies various programs and other staff:
 - A. Maintains positive relationships with clients, staff, parents, outside agencies and the community.
 - B. Assists client and family to find appropriate treatment, serves and monitors continued appropriateness of the services.
2. Provides direct contact with clients and family in their natural environment:
 - A. Serves as client advocate, acting in client's best interest at all times.
 - B. Provides support to clients and their families, school officials, court systems, etc. through education and referrals.
 - C. Maintains necessary and pertinent records and files.
 - D. Analyzes and recommends new programs to Coordinator.
 - E. Implements program as directed.
3. Attends staff and program planning meetings, in-service training, workshops, conferences, consultations, educational opportunities pertaining to the program and acquires knowledge of community resources.

KNOWLEDGE, SKILLS, AND ABILITIES:

1. Knowledge of:
 - A. Departmental policies and procedures.
 - B. Agency and community social service availability.
 - C. Case management techniques.
2. Ability to:
 - A. Communicate effectively verbally and in writing.
 - B. Maintain accurate records.
 - C. Define problem, collect data, establish facts and draw valid conclusion.
 - D. Develop and maintain appropriate working relationships with supervisors, co-workers, clients, agencies, and the general public.
 - E. Exercise sound judgement.
 - F. Handle clients emotionally and physically.
 - G. Act rationally, decisively, effectively and quickly under pressure.

GATEWAY
CASE MANAGEMENT
NETWORK PLAN

CASE NAME: _____

INITIAL REVIEW DATE: _____

GATEWAY CASE MANAGER: _____
LEAD CASE MANAGER : _____

NEXT REVIEW DATE: _____

NEEDS:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

OPTIONS FOR SERVICE:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

GATEWAY
NETWORK PLAN

Provider Name: _____
Relationship: _____
Address: _____
Phone: _____

PLAN with frequency of contact:

Provider Name: _____
Relationship: _____
Address: _____
Phone: _____

PLAN with frequency of contact:

Provider Name: _____
Relationship: _____
Address: _____
Phone: _____

PLAN with frequency of contact:

Provider Name: _____
Relationship: _____
Address: _____
Phone: _____

PLAN with frequency of contact:

Provider Name: _____
Relationship: _____
Address: _____
Phone: _____

PLAN with frequency of contact:

Provider Name: _____
Relationship: _____
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Phone: _____

Plan with frequency of contact:

Provider Name: _____
Relationship: _____
Address: _____
Phone: _____

PLAN with frequency of contact:

Provider Name: _____
Relationship: _____
Address: _____
Phone: _____

PLAN with frequency of contact:

Provider Name: _____
Relationship: _____
Address: _____
Phone: _____

Plan with frequency of contact:

Profiles of Local Systems of Care

**for Children and Adolescents
with Severe Emotional Disturbances**

STARK COUNTY, OHIO

**Prepared By:
Beth A. Stroul, M.Ed.**

**CASSP Technical Assistance Center
Center for Child Health & Mental Health Policy
Georgetown University Child Development Center**

**Funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)**

July 1992

INTRODUCTION

This case study was developed through a project conducted by the Child and Adolescent Service System Program (CASSP) Technical Assistance Center at Georgetown University. It is part of a descriptive study of local systems of care which was initiated in 1990 and funded by the National Institute of Mental Health (NIMH), Child and Adolescent Service System Program. The project has involved identifying and studying communities which have made substantial progress toward developing comprehensive, coordinated, community-based systems of care for children and adolescents who are severely emotionally disturbed and their families. Individual case studies of each local system of care are the products of this effort and are intended as technical assistance resources.

Systems of care for troubled children and adolescents have been of great interest over the last several years. In 1982, Knitzer estimated in her seminal study, Unclaimed Children, that of the three million children with serious emotional disturbances, two-thirds were receiving no treatment whatsoever and countless others were receiving inappropriately restrictive care because of the lack of community-based service alternatives. In 1986, Saxe conducted a study for the Office of Technology Assessment of the United States Congress which confirmed Knitzer's findings and stated that "Mental health problems are a source of suffering for children, difficulties for their families, and great loss for society. Though such problems are sometimes tragic, an even greater tragedy may be that we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available."

In response to these problems and to the growing number of calls for change, the National Institute of Mental Health launched the Child and Adolescent Service System Program (CASSP) in 1984 to assist states and communities in developing community-based systems of care for this underserved population. Through grants and technical assistance activities, CASSP has supported the development of interagency efforts to improve the services provided to the most troubled children and youth and their families. To provide a conceptual framework for system of care development, CASSP supported the publishing of A System of Care for Severely Emotionally Disturbed Children & Youth by Stroul and Friedman in 1986. This monograph has been called a blueprint for action in the child mental health field, and it describes the various service options required by these youngsters and the need for services across all of the relevant child-serving agencies. From these components, Stroul and Friedman proposed a design for a "system of care" encompassing both the full range of services and the mechanisms required for the assurance of their appropriate delivery. Currently, there is widespread agreement that community-based systems of care for youngsters who are severely emotionally disturbed and their families are needed, and the development of these systems has become a national goal.

Despite the calls for such systems of care, until recently there were few, if any, examples of local systems of care which combined an array of community-based services with other essential elements including interagency collaboration and case management. Today, there is what might be described as an explosion of activity related to system of care development. The activities of CASSP, which have now involved every state, have played a crucial role in stimulating system development at state and local levels. Increased attention to children's

mental health by advocacy groups also has had a major impact. Further, system building has been advanced significantly by initiatives such as the Robert Wood Johnson Foundation's Mental Health Services Program for Youth, which has provided funds for the development of systems of care in selected local areas, and extensive system development initiatives in a number of states. As a result, many communities now have evolving systems of care which can be studied and described. Descriptions of the system building approach and experience of these communities are designed to assist other communities which are attempting to develop such systems.

Potential sites for inclusion in this study were identified through a process of consultation with key informants including individuals at national and state levels who have extensive knowledge of developments in the children's mental health field and in the development of local systems of care in particular. Through these initial discussions, approximately 20 communities were identified. These localities were characterized as having made significant progress toward the development of community-based systems of care consistent with the philosophy and principles which have been promoted by CASSP and which are displayed on the following page. Accordingly, an attempt was made to locate local systems which are family focused, emphasize treatment in the least restrictive environment, involve multiple agencies, individualize services, and so forth. Similarly, an attempt was made to locate systems which have moved beyond the more traditional outpatient, inpatient, and residential treatment services and have begun to develop a more complete and balanced array of nonresidential and residential services including home-based services, day treatment, crisis services, therapeutic foster care, respite care, case management and others.

The second phase of the selection process involved extensive telephone interviews with a representative from each site to obtain detailed information about the array of services available in the community, the nature and functioning of the system level coordination mechanisms, and the nature and functioning of the client level coordination or case management mechanisms. In addition, information was collected about any special system activities related to such issues as financing the system, evaluating the system, involving families in planning and delivering services, and enhancing the cultural competence of the system of care. A chart was prepared for each potential site summarizing the service array, system level coordination mechanisms, and client level coordination mechanisms.

Selection of sites for further study was accomplished with the assistance of an advisory committee and was based on the following set of criteria:

1. Must have a range of services in place (home-based services, crisis services, therapeutic foster care, and others).
2. Must have interagency coordination mechanisms in place.
3. Must have client level coordination mechanisms in place, e.g., case management.
4. Must be a sufficiently well-developed local system to be able to serve as a useful example to the field and to receive national attention.

CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.
5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.
6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
10. Emotionally disturbed children should receive culturally competent services which are sensitive and responsive to cultural differences and special needs and are provided without regard to race, religion, national origin, sex, physical disability, or other characteristics.

5. Should have some noteworthy activities in one or more areas including family involvement, cultural competence, transition, high-risk children and adolescents, financing, and evaluation.

An initial group of five communities was selected for site visits by the project team. The site visits generally involved spending three to four days in each community engaged in a variety of activities designed to provide insight into the functioning of the system of care. These activities included interviews with a number of individuals and groups including key system managers, senior management representatives of the major child-serving agencies (mental health, child welfare, education, and juvenile justice), case managers, youngsters, parents, and advocates. Additionally, the schedules included visits to three or more service components in the system of care where activities were observed and discussions held with program managers, staff, and, in some cases, clients. An important aspect of the site visits was observing the functioning of interagency entities. Site visitors attended meetings of interagency entities focusing on system-level coordination as well as meetings of interagency teams organized for the purpose of creating individualized service plans for specific youngsters and their families. The site visits provided a wealth of information about each system of care -- its developmental milestones, strengths, and obstacles yet to be overcome.

The sample of communities studied yield valuable insights into the process of building systems of care. Due to an enormous increase in system development activities in communities across the nation, there currently are many more noteworthy examples of local systems of care. It should be emphasized that none of the communities selected for study have fully developed systems of care, and all are struggling to overcome financial and other obstacles to system development. Rather, they are communities which have succeeded in putting some basic building blocks into place and have demonstrated progress toward achieving system development goals. The resulting case studies are intended to serve as technical assistance resources for other states and communities as they approach the challenge of developing local systems of care for youngsters with severe emotional disturbances and their families.

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PROFILE OF A SYSTEM OF CARE: STARK COUNTY, OHIO

I. COMMUNITY CONTEXT

The system of care to be described serves children and families of Stark County, Ohio, which is located in the northeastern part of the state. The county is not far from other major Ohio cities, with Akron about 30 miles north, Cleveland about 50 miles north, and Columbus about 120 miles southwest. Stark County is the seventh largest county in Ohio and has a population of 367,585. Half of the county's population is concentrated in the central area which includes Canton and North Canton. While the Canton area is described as urban, the surrounding areas are described as suburban and rural. Within a mere ten minutes of downtown Canton, the landscape shifts to primarily large, rural farming districts.

In addition to the concentration of population in the Canton/North Canton area, Stark County has two additional population centers -- Massillon and Alliance. Due to the distances between the three population centers and the lack of a good transportation system linking them, services are typically offered in each of the three areas. As might be predicted, the Canton/North Canton area boasts the richest array of services, and the service array tends to be less well developed in the Massillon and Alliance areas.

The population of Stark County is predominantly white, nearly 92 percent. Census data indicate that 8.3 percent of the population belongs to minority groups, with most being African American (7.5 percent) and the rest being Hispanic. Much of the county's African American population is concentrated in Canton; approximately 18.2 percent of the population of the City of Canton is African American, and African American children comprise about 30 percent of the student population of the Canton City Schools.

Census data indicate that the median family income in 1990 was \$29,425, and about 13.5 percent of Stark County residents had household incomes below the poverty level. Based on a more realistic standard for assessing poverty (incomes below 125 percent of the poverty level), it is estimated that nearly 18 percent of Stark County's families can be considered poor. In fact, poverty in Stark County has increased by 15 percent since 1985, and the county's poverty rate exceeds the statewide average by 20 percent. A significant and growing group in Stark County consists of the working poor.

Historically, Stark County has been a leading manufacturing center. In 1980, the largest industry in the county was manufacturing, which accounted for nearly 36 percent of the county's jobs. Headquarters and plants have been located in Stark County for many large industries including alloy steel, roller bearings, vacuum cleaners, building materials, gasoline and diesel engines, and bank security and transaction technology. Along with the rest of the Midwest, the county has suffered from the scaling back of the steel and rubber industries during the 1970s and 1980s.

While plant closings have resulted in losses in jobs, it was reported that Stark County was not as devastated by the industrial declines as were other areas. This is attributed to greater diversification as well as continued investments by large companies such as Timken Steel.

Despite the economic crisis, the county still has an industrial base. Further, the relatively low cost of living has attracted many new residents, and the Canton/North Canton area has experienced rapid growth over the past 15 years.

Currently, the major employers in the county include Timken Roller Bearing and Specialty Steel, Hoover, Diebold, and Republic Engineered Steel. In addition, large numbers of citizens are employed by two general hospitals (Timken Mercy Medical Center and Aultman Hospital) and the Massillon Psychiatric Center, a state hospital serving adults with mental illness. Agriculture also contributes to the county's economic base. Not unlike other midwestern communities, Stark County's economy is moving from a primarily industrial job base to an economy that includes more service occupations as well as manufacturing and agriculture.

The county offers a variety of cultural, recreational, and educational opportunities. It is perhaps best known for the Pro Football Hall of Fame, a significant tourist attraction. Canton was selected at the site for the Hall of Fame because the National Football League was founded there in 1920. There is a strong interest in sports in the area, from the minor league Canton Indians and the professional soccer team, the Canton Invaders, to the sports teams in nearby Cleveland. The community is home to a symphony orchestra, civic opera, ballet company, and players guild and has museums including the Hoover Historical Center and the William McKinley Museum of History, Science, and Industry. Two four-year liberal arts colleges are located in Stark County (Malone College and Walsh College) as well as the Stark Technical College and the Stark County campus of Kent State University.

Stark County faces a number of significant problems. Transportation was among those cited most frequently. The lack of a good public transportation system affects the community as a whole and creates formidable barriers to accessing services. Another frequently cited problem was poverty, particularly the growing segment of the population which can be classified as working poor. Family instability also is perceived as a major problem for the community, since Stark County has one of the higher divorce rates in the state.

In order to explore the needs of community in a systematic way, the United Way of Central Stark County sponsored a county-wide needs assessment which was completed in 1990. Focus groups, telephone surveys, information and referral tabulations, and other data and reports were analyzed to identify needs and rank them in priority order. This process resulted in the identification of priority needs for the county including:

- | | |
|-------------------------------------|----------------------------------|
| o Substance Abuse | o Hunger/Nutrition |
| o Parenting/Family Integration | o Affordable Housing |
| o Mental Health | o Pregnancy/Family Planning |
| o Abuse/Neglect | o Day Care |
| o Emergency Income Assistance | o Transportation |
| o Short-term Shelter | |

The highest ranked need reflects the community's growing concern about substance abuse. Crack houses have been identified in Stark County, and there has been a 90 to 100 percent increase in the incidence of crack babies in the past several years as well as a significant increase in requests for services related to crack addiction. The Department of Human Services (DHS) reported that 68 percent of all child abuse and neglect cases handled in 1990

involved substance abuse in some way. Of significant concern is the growing incidence of gang violence related to drug abuse, particularly in one section of Canton. Gangs from the Los Angeles area have been identified in the county, a cause for alarm among citizens, law enforcement, and human service providers.

Along with substance abuse services, other needs receiving the highest rankings include supports for parenting and families, mental health services, and services to address child abuse and neglect. The four highest priority needs discerned by the United Way needs assessment process are all directly associated with the current activities of the Stark County system of care for troubled children and families.

The human service system at the state level in Ohio consists of seven cabinet level departments including Departments of Mental Health, Mental Retardation/Developmental Disabilities, Youth Services, Human Services, Health, Education, and the more recently created Department of Alcohol and Drug Addiction Services. While these agencies fund, regulate, and oversee local services, the service system in Ohio is largely county operated with community boards directing and planning service delivery in many of the categorical areas. Thus, the service system environment in Stark County is seen as one of local control and autonomy, with community-level responsibility and decision making.

The following child-serving agencies and systems provide services in Stark County and are key players in the system of care:

- o Mental Health: Stark County Community Mental Health Board and Child and Adolescent Service Center
- o Child Welfare: Stark County Department of Human Services
- o Education: Stark County Board of Education and 17 School Districts with Boards of Education including Canton City Schools
- o Juvenile Justice: Stark County Family Court, Regional Office of Ohio Department of Youth Services, and the Stark County Prosecutor's Office
- o Health: Stark County Health Department, Canton City Health Department, Massillon Health Department, and Alliance Health Department
- o Mental Retardation: Stark County Board of Mental Retardation and Developmental Disabilities
- o Substance Abuse: Alcohol and Drug Addiction Services Board of Stark County

II. BACKGROUND AND HISTORY OF SYSTEM OF CARE DEVELOPMENT

History of System of Care

System building efforts on behalf of children and youth in Stark County can be traced back to the passage of a mental health levy in 1973. At that time, there was only one mental health provider agency in the county, the Central Mental Health Center. This mental health center provided services almost exclusively to adults, although there was one occupational therapist on staff who provided services to children. The Stark County Community Mental Health Board appealed to the citizens for additional mental health funding through the levy, with a significant portion of this funding to be applied to developing a capacity to provide mental health services to children.

With the passage of the levy, the Mental Health Board appointed a children's committee to make recommendations on how best to proceed in order to develop and coordinate comprehensive mental health services for children and adolescents. The primary recommendation of this committee was to create a separate, private nonprofit agency to provide mental health services to children. This proposal created a great deal of controversy and was vigorously debated. In 1975 the Stark County Community Mental Health Board approved the proposal to create a separate children's agency by the narrowest of margins, only one vote. As a result, the Child and Adolescent Service Center (CASC) was founded in 1976 with a staff of six professionals and funding of approximately \$170,000 from the Mental Health Board.

Those in favor of the formation of a separate children's agency felt that such an organizational arrangement would offer a number of advantages including creating more visibility for the needs of children, raising confidence in the quality of services, facilitating prospects for obtaining funding, and attracting more professionals with interest and expertise in children's mental health. In fact, these predictions have largely come true. Currently, the CASC has a staff of more than 30 professionals and a budget of more than \$2.6 million for children's services, significantly more than comparable communities without a separate children's agency. While this assertion has not been tested, it appears that the Ohio counties with separate children's agencies have garnered greater attention and resources for children's services than have other counties where children's services tend to be overshadowed by adult services. Thus, the formation of the CASC is considered a principal milestone in the development of the Stark County system of care.

Once the CASC was established, it was given a great deal of latitude and support by the Mental Health Board to create a system of care, and steady progress has been achieved over time. The basic philosophy for this system of care was established early in the developmental process. The same children's committee which recommended the creation of a children's agency also provided a philosophical base for the agency and its activities. From the beginning, system development activities were guided by the desire to view the child in the context of the family and to provide treatment within or close to the child's home. Concern about separating children from their families and relying on out-of-community or out-of-state placements led the CASC to explore community-based programmatic approaches as it expanded its service array. Further, a board of trustees to guide the CASC was developed

and included representatives of the other key child-serving systems. This group was the first interagency entity formed to plan, develop, oversee, and coordinate the county's evolving system of care for children.

With a clear philosophical base and interagency guidance, the CASC proceeded to develop its service capacity. In 1980, CASC was awarded an initial community mental health center operations grant of \$280,000. This infusion of funds allowed the CASC to move beyond outpatient counseling services and to establish and begin to pursue the long-range goal of developing a comprehensive continuum of care emphasizing an array of nonresidential services.

This commitment to focus on nonresidential service components is evidenced in key decisions to invest in day treatment programs rather than in residential treatment. In 1980, the CASC assumed responsibility for a preschool day treatment program that had previously been run by United Cerebral Palsy and shifted this program to a defined mental health focus. Shortly thereafter, an interagency task force was established to explore the need for a residential treatment program or some type of alternative. Based upon the work of this task force, the CASC expanded its day treatment capacity by opening, in cooperation with the Canton City Schools, a school-age day treatment program in 1983. Another service element added during this time was called the Cities in School Program and involved sending staff into the Canton City Schools to provide consultation and therapeutic services and to coordinate service delivery to students. Assessment, consultation, and therapeutic services also were offered to the juvenile justice and child welfare systems. Thus, during the early 1980s, a strategic plan for the development of a broad continuum of services for children in Stark County began to take shape.

System development efforts in Stark County were furthered in 1984 by the convening of the Stark County Interagency Cluster by a Family Court judge. The organization of the Cluster was in response to an executive order signed by Governor Richard Celeste which required that each county establish a "cluster" of youth-serving agencies to coordinate and develop services for multineed youngsters. All key child-serving agencies became Cluster members and proceeded to work together to continue to build the county's system of care. As mandated by the State of Ohio, the Cluster reviewed cases of multineed children whose needs were not being met by the existing service system; a protocol for Cluster referrals was developed. By 1985, there were 55 children in out-of-county psychiatric residential placements as compared with 141 when the CASC was created in 1976. This significant reduction was attributed to the expanded service array available in the community and to enhanced interagency collaboration in serving children and their families.

As additional funding sources became available, the system of care was developed further. For example, a grant from the Ohio Department of Mental Health (ODMH) in 1985 allowed the addition of case managers and therapists to the Day Treatment Program. The availability of ODMH funds for children with severe emotional disorders (508K funds) in 1986 enabled the community to develop an intensive home-based service program called Therapeutic In-Home Emergency Services (TIES). Interestingly, most other Ohio counties initially used 508K funds to develop residential services and some day treatment. Respondents believe that Stark County may be the only county which developed a home-

based service capacity at that time, a move which was consistent with the philosophy of keeping youngsters at home and in the community to the greatest possible extent.

The Child and Family Advocacy Program, established in 1987, is a multiagency collaborative program to provide and coordinate services for children who have been sexually abused. The Youth Sex Offender Program, started in 1988 with a grant, is a program jointly funded by the Mental Health Board and the Family Court. Additional grant funds received from the ODMH in 1989 enabled the community to develop mental health case management and intensive home-based services. With the addition of these services, by 1991 there were only 15 youngsters in out-of-county placements, and the utilization of Sagamore Hills Children's Psychiatric Hospital, the state hospital for children, had dropped substantially as well.

The ODMH grant which supported the development of case management and intensive home-based services also supported an activity called "system of care enhancement." This process has proven to be vital to the continued evolution and refinement of the system of care in Stark County. It has centered around a series of retreats, coordinated by an outside facilitator, which have served as vehicles for the Cluster to deliberate, reach agreement, plan, and establish priorities on critical issues facing the county's system of care. In effect, the retreats were used to design a blueprint for the development of the system of care. The first Cluster retreat was used to develop both a vision statement and guiding principles for the system. Subsequent retreats have focused on issues including coordination of case management, establishing therapeutic foster care, establishing a cluster coordinator position, research and evaluation, and system collaboration. During one retreat, a role play of a case presentation at a Cluster meeting was used to plan how cases should be presented and what would be needed to make the interagency case review process work. A retreat held in 1991 was devoted to considering approaches to funding services and ultimately resulted in a contract defining each agency's financial commitment to serving children coming before the Cluster. In all, five such retreats have been held. All respondents agreed that the retreats, along with the assistance of the outside facilitator, have been instrumental in designing and implementing the Stark County system of care.

In identifying the critical events in the development of the Stark County system of care to date, there was nearly universal agreement that system development was profoundly affected by: 1) the creation of the CASC as a separate children's mental health agency, 2) the decision to invest in day treatment programs rather than residential programs thereby setting the precedent for continued system development, and 3) the use of an outside facilitator to work with the Cluster in a series of retreats for system planning and coordination purposes.

State Influences of System of Care Development

Ohio is characterized as a state with strong local control and responsibility for service provision. Nevertheless, the state government has had a significant influence on system of care development in Stark County and throughout Ohio. One area of clear influence has been the state's leadership in emphasizing and requiring interagency collaboration and coordination in service delivery, initiated during the administration of Governor Richard Celeste. In March 1984, Governor Celeste signed an executive order requiring interagency cooperation in service delivery to multineed children. This executive order established an Interdepartmental Cluster for Services to Youth at the state level, including the six state

departments involved in serving children and adolescents. The order also directed county agencies to work cooperatively with other agencies in their respective districts, calling for the formation of local clusters to review specific cases of children with severe and multiple problems, develop individual service plans, and access existing or alternative programs and funding to meet the needs of these children. The order specified that children and adolescents could be referred to the State Interdepartmental Cluster after all attempts to resolve problems at the local level have failed. It also included a provision specifying the sharing of funds for planned services based upon appropriate agency involvement in each case.

In 1987, the requirement for state and local clusters to coordinate services for multineed youth was codified in legislation. There are now active clusters in most Ohio counties. While evidence of interagency planning and collaboration in Stark County preceded the executive order, this mandate spurred the county into formalizing its interagency efforts. Further, the Stark County Cluster has played an indispensable role in conceptualizing and implementing the system of care. Thus, the state mandates relative to the formation of interagency clusters have had a positive and significant effect in Stark County.

State legislation also created the Children's Cluster Fund to support expenses of the State Interdepartmental Cluster and to allow for direct grants from the State Cluster to local cluster participants. The grants could be used for partial support payments and reimbursement for the maintenance and treatment costs of multineed children who come to the attention of the State Cluster and also for the development of service delivery programs for multineed children.

While some counties have received these "system of care grants" from the State Cluster, Stark County has not been the beneficiary of such funding. In fact, respondents indicated that, in contrast to other Ohio counties, system development in Stark County has proceeded with few specialized grants from the state. The beginnings of the county's system of care philosophy and its interagency planning efforts both predate similar developments at the state level. Respondents emphasized that the directions for system development in the county were established as a result of local initiatives and that the state role has largely been supportive and facilitative. The state role has been primarily to establish a climate that is conducive to the growth of a system of care in Stark County, to reinforce the directions adopted by the county, and to provide technical assistance.

Another potential state influence on system of care development is the Mental Health Act of 1988 passed by the Ohio legislature. This act, which became effective in fiscal year 1990, gives local mental health boards the responsibility for administering both inpatient and outpatient mental health funds. Boards are authorized to take a specified percentage of their allocation for inpatient care and utilize it for alternatives to hospitalization. Ideally, this legislation was intended to create incentives for reduced reliance on hospitals and to increase development of community services and supports. In reality, however, the rising costs of hospital care and serving severely disabled persons in the community have made it difficult to realize this goal within available levels of funding. To rectify this situation, an association of mental health boards in the northeast area of Ohio has recommended the closure of Sagamore Hills Hospital to ODMH. This would ostensibly free resources for the development of community-based alternatives.

During the site visit, no instances were noted suggesting ways in which the state has hindered system development in Stark County. On the whole, it appears that the state has had a positive influence on the course of system development in Stark County by encouraging interagency collaboration and by providing philosophical support and technical assistance.

III. PHILOSOPHY AND GOALS

As noted, the roots of the philosophy of the Stark County system of care can be traced to the children's committee which was instrumental in advocating the formation of a separate children's mental health agency. Though the process began nearly 20 years ago, the basic elements of the philosophy have remained constant over time. Four basic elements appear central to the philosophy of the Stark County system:

- o **Interagency Collaboration** - The system of care is based upon the premise that children and families have problems which relate to multiple systems and that no one agency alone can be effective in serving them. The child-serving agencies in the community consistently express the conviction that agencies cannot be as effective individually as they can be together, and that no single agency has either the ability or resources to meet all the needs of a child and family. This philosophy of interagency collaboration has been well-ingrained in Stark County, and interagency participation is evident in planning and service delivery activities.
- o **Providing Services within the Home and Community** - A belief in providing services to youngsters within their homes and within the community has been evident throughout the development of the system of care. The choices to develop day treatment and home-based services as alternatives to residential services were based upon a strong philosophical commitment to provide services in the least restrictive setting, to keep youngsters with their families to the greatest extent possible, and to keep youngsters within the county to the greatest extent possible.
- o **Family Focus** - A third element of Stark County's philosophy is that the child must be viewed as a member of a family. In this context, a primary role of the system of care is to support positive family functioning. The family-centered approach embraced by the system of care was evident both in documents and in discussions with agency executives and staff. Throughout the planning and delivery of services, the system focuses on the needs of the entire family and on involving parents as partners.
- o **Strengths Focus** - Another recurring theme in both documents and discussion is the need to focus on the child's and family's strengths rather than on pathology. This philosophy compels the system of care to seek opportunities to build on strengths, even for the most troubled children and families. An interagency service planning process, used for difficult cases, centers on the identification of strengths that can be employed creatively in the development of service and treatment plans.

The philosophy and principles governing service delivery have been refined over time. The first Cluster retreat, held in 1989, was devoted to articulating the vision and driving

principles for the county's system of care. While some communities may struggle to reach consensus on their values and principles, this was characterized as a relatively easy task in Stark County. Many of the elements of the philosophy had been in place for some time, necessitating refinement rather than reinvention. The retreat resulted in the development of a vision statement for the Stark County system:

"We visualize a unified system that energizes all services around each child's needs so they can realize their maximum potential. This system provides positive alternatives within the community so that the child will have the opportunity to build on his/her strengths. This system effectively supports positive family functioning and nurtures children in a socially, emotionally, and educationally sound environment which persists into adult life."

The driving principles for the system of care developed during the retreat reflect the philosophical commitment to interagency collaboration, providing services within the home and community, focusing on families, and focusing on strengths. These principles include:

- o "Identify and accept without exception all those who are in need through a proper and appropriate assessment.
- o Child centered and individualized service with a family focus.
- o Develop an aggressive program that wraps services around the child's/family's needs and provides whatever services are needed. (Whatever it takes!)
- o The community is part of the solution and not the problem.
- o Everyone has the right to life, liberty, and happiness.
- o Parents of the youth are involved as partners in the definition of issues as well as the solutions.
- o Have the least restrictive, community-based services.
- o Have community awareness of various systems that provide services to children.
- o The focus is on prevention and the child's and family's strengths, rather than pathology.
- o Everyone has self-worth, and change can occur.
- o The system of care will accept every child no matter what his or her disability with a "no eject, no reject" philosophy."

The goals of Stark County's system of care parallel the elements of its philosophy and include the following:

- o To provide a unified system of service delivery.
- o To provide services which enable children to remain within their homes and community to the greatest possible extent.
- o To reduce the numbers of children in out-of-home and out-of-county placements.

IV. TARGET POPULATION

As the Cluster designed a blueprint for a system of care in Stark County, one of the major issues considered was defining the target population. During the first creative planning retreat, the Cluster generated a set of identifying factors to set parameters for the population to be served. Two primary elements appear to define the target population from the perspective of the Cluster -- multiple needs and difficulty meeting these needs within existing services. Thus, the Cluster defines the target population for the system of care as children with multiple needs and their families for whom current or existing services have been inadequate or unsuccessful. Some of the identifying factors for the target population cited by the Cluster specify youngsters needing multiple systems for support, needing highly specialized or intensive services, at high risk for institutionalization, or presenting as "failures" within individual agencies. In May 1992, the Cluster adopted a formal definition for its target population, specifying the following criteria:

- o Stark County resident
- o 0 - 18 years of age (through 21 in many cases)
- o Involved in at least three child-serving systems (Juvenile Justice, Child Protection, Health, Mental Health, Mental Retardation/Developmental Disabilities, Alcohol and Drug, Experiencing Problems in Education)
- o Child's multiple needs must exist within the child's physical, health, medical, emotional, developmental or intellectual functioning as primary obstacles to the child's optimum growth and development.

The target population is further defined by a planning document prepared by the Stark County Community Mental Health Board. Based on discrepancies between the needs of children and adolescents and available resources, the Board proposed priorities for services within the mental health system as follows:

A. Children and adolescents with a mental health diagnosis plus:

- o Long-term psychiatric hospitalization
- o Residential placement
- o Out-of-county/state placement
- o Cluster involved
- o Out-of-home placement

B. Children and adolescents with a mental health diagnosis plus:

- o School drop-out/special education placement
- o Detention/juvenile corrections facility
- o Teen parent
- o Homeless/living along
- o Foster home
- o Drug/alcohol abuse
- o AIDS related

C. Children and adolescents with a mental health diagnosis plus at least three risk factors (e.g., low income, single parent family, abused, etc.)

D. Children and adolescents who request services

An additional definitional tool is provided by ODMH which has established criteria for certifying youngsters as severely emotionally disturbed (508K certification). The criteria for such certification specify that youngsters have the following characteristics:

- o Age birth to 18 years
- o Marked to severe impairment within the past six months
- o Impairment which seriously disrupts academic or developmental progress
- o Impairment which seriously disrupts family or interpersonal relationships
- o Problems leading to the impairment which have lasted six months or longer
- o Requires the services of other youth-serving systems, e.g., education, human services, juvenile court, health, MR/DD, and youth services

These definitions appear compatible in that they all emphasize serving youngsters who have multiple needs and are involved with multiple systems, youngsters with serious problems and needing intensive services, and youngsters in or at risk for out-of-home or out-of-county placements of various types.

Data were provided to describe youngsters coming before the Cluster as well as youngsters served by the CASC. A profile of 25 youngsters presented to the Cluster from 1984 to 1989 shows that the majority were male (76 percent) ranging in age from 9 to 19, with the modal age categories being 15 and 16. Nearly 80 percent of the youngsters had IQ scores below 84, and 80 percent came from families which were not intact. An overwhelming majority of the youngsters (88 percent) had previous out-of-home placements, the most frequent of which was at Sagamore Hills Hospital where one-third of these youngsters had previous episodes of psychiatric care. All of the youngsters had previous involvement with multiple agencies; over 70 percent were involved with three, four, or five agencies. These data indicate that the Cluster does appear to be serving youngsters with multiple needs who are at risk for out-of-home placements and for whom existing services from multiple agencies have proven ineffective.

CASC data from fiscal year 1991 suggest that the population served by that agency also falls within established priority groups. More than 85 percent of the agency's 1991 client population was certified as severely emotionally disturbed based upon the state's 508K

certification criteria. About 40 percent of the client population had level of functioning scores of less than 50 on the Global Assessment Scale, indicating serious impairments in all spheres. The client population exhibited risk factors as well; more than 40 percent lived in single mother households, and nearly 70 percent were eligible for some type of government entitlement suggesting high levels of poverty. About two-thirds of the youngsters were referred to the CASC by another agency or system, most frequently by the child welfare or juvenile justice systems or by the schools. About 15 percent of the population served by the CASC belonged to minority groups, almost exclusively African American.

V. ORGANIZATION OF THE SYSTEM

System Management

The organizing structure for the system of care in Stark County is provided by the Cluster. Within this framework, all agencies participate in system management in accordance with a deliberate decision not to have a lead agency. The Cluster itself was characterized as the lead agency, a collective body assuming responsibility for planning and overseeing the system of care. The decision not to have a designated lead agency appears to be based upon the assumption that the system would be less effective if one agency took the lead, whereas joint management would lead to joint ownership of the system of care. Further, respondents indicated that with a joint management approach, it is more difficult for individual agencies to "cop out" or shift their responsibility onto another agency. Based upon this approach, responsibility for chairing the Cluster rotates among the participating agencies on a regular basis, every six months. At the time of the site visit, the Executive Director of the Mental Health Board was serving as Cluster Chair to be followed by the Administrator of the Family and Children's Services Unit (the Cluster representative from DHS.)

Until recently, Stark County did not receive any special funding to support the operations of the Cluster. The Cluster functioned within the administrative budgets of participating agencies. For example, Cluster meetings are held in the conference room of the Mental Health Board, and the Mental Health Board also has provided secretarial support for Cluster activities. The Cluster considered potential funding opportunities for a cluster coordinator position to manage Cluster activities and coordinate activities related to the system of care. A number of options were explored including approaching the County Commissioners to provide funds for such a position and blending funds from the participating agencies for this purpose. When the Mental Health Board recruited a Children's Coordinator, this individual naturally began to assume some of these coordinating functions. Ultimately, the Cluster decided that the Children's Coordinator from the Mental Health Board would fulfill the role of cluster coordinator, and, as a result, the need for a separate cluster coordinator position has diminished. In December 1991, the Cluster and Mental Health Board officially recognized that the Children's Coordinator was, in fact, serving as cluster coordinator. Subsequently, a grant proposal was submitted to the State Level Cluster, and funds were received to support 50 percent of the salary of the Children's Coordinator in recognition of the crucial role she fulfills for the local Cluster.

Role of Participating Agencies

- o Mental Health: Stark County Community Mental Health Board and Child and Adolescent Service Center (CASC)

The Stark County Community Mental Health Board serves as the administrative and fiscal monitoring agent for mental health services in Stark County. The Board contracts with various provider agencies in the community for mental health services for children and adults. Unlike mental health boards in many other communities, the Stark County Board has had a long-standing commitment to children's services. This is evidenced by its decision in 1975 to create a separate children's agency and in its provision of support and resources for the development of a service array for children. In 1990, a new position was created at the Board for a Children's Coordinator, further solidifying the Board's commitment to building the county's system of care. The Children's Coordinator plays a key role in coordinating the activities of the Cluster and planning for the system of care.

The major contract agency of the Mental Health Board for children's services is the CASC. The CASC, founded in 1976, currently employs approximately 30 professionals, has a budget of over \$2.6 million, and is accredited by the Council on Accreditation for Services to Children and Families, Inc. The CASC offers a wide range of mental health services including individual, group, and family counseling; psychological testing; psychiatric evaluation and medication services; day treatment; case management; child management groups; consultation, education, and prevention services; intensive home-based services; and services for victims of child sexual abuse as well as for youthful sex offenders. From its inception, the CASC has reached out to other child-serving agencies, involving them on its board and other advisory structures. Thus, other community agencies have played active roles in establishing directions for the CASC's continued development. A perennial problem for the CASC has been a high demand for its services as compared with its service capacity. The result has been a wait list for most programs and an ongoing tension between the desire to serve more people versus the desire to provide highly intensive and effective services to those judged most in need. As the primary service provider agency for children's mental health in the county, the CASC also is represented on the Cluster.

- o Child Welfare: Stark County Department of Human Services (DHS)

The Social Services Division of the Stark County DHS provides a variety of child welfare services. Intake units provide protective services for children by investigating reports of alleged child abuse and neglect, with over 3600 referrals investigated in 1990. In cases of alleged sexual abuse and abuse cases with potential criminal involvement, teams of sheriffs and social workers are assigned to conduct investigations jointly. Family service units provide protective services on an ongoing basis to families requiring continued supervision and intervention in order to insure the well-being of children and to maintain the family unit.

In addition to protective services, a range of child placement services are offered by DHS. Foster care services include recruiting, licensing, and training foster families

and providing supervision and case management for youngsters in foster care. A group home system with two homes for boys and two homes for girls is operated in the county, with approximately 30 children in group home care at any given time. Most children in the group homes have some degree of emotional or behavioral problem. DHS contracts for residential treatment for youngsters needing specialized treatment for emotional disorders. An adoption unit provides services to children who are legally free for adoption. Other services provided by DHS include a shelter system, parent aide services, single parent services, and day care services.

In 1990, a children's services levy was passed in Stark County. The levy will create a stable base of funding for the delivery of children's services for a five-year period. Respondents indicated that the passage of the levy demonstrated the commitment and concern of the general public about the needs of children and families in the community.

- o Education: Stark County Board of Education and 17 School Districts with Boards of Education including Canton City Schools

Stark County contains 17 autonomous school districts, each with its own board of education and superintendent. County-wide, over 12,000 children are identified as needing special education services. Most of the local school districts provide special education services for high incidence problems. For low incidence disabilities, services are provided by the Stark County Board of Education. Among the county-operated special education units are classrooms for youngsters with severe behavioral handicaps. The County Board of Education contracts with the CASC to provide a psychologist to consult with teachers and provide group counseling for youngsters in special education classes. The Stark County Board of Education also provides school psychologists and other specialized services that the smaller districts cannot afford individually. The County Board of Education is represented on the Cluster.

The largest of the local school districts is the Canton City Schools. The Department of Special Education offers a comprehensive range of special education and related services and supports for all handicapping conditions, including a severe behavior handicapped program. The Canton City school system participates actively in the Cluster process and the system of care. For example, the Day Treatment Program, which is accessible to all children in Stark County, is a collaborative program between the Canton City Schools, the CASC, and DHS. In addition, the Director of Special Education attends Cluster meetings and has taken responsibility for sharing information with the other school districts through regularly held roundtables for special education directors. Representatives of other school districts typically participate in the Cluster process on an individual case basis, but are less actively involved in system planning and coordination activities.

Several activities have been undertaken to improve both regular and special education in the community. One of these involved forming a task force with multiagency representation to identify the problems involved in serving children with emotional problems and to develop recommendations. One result of this Severe Behavioral Handicapped Task Force was a proposal to develop a collaborative program between

the schools, court, and mental health agencies to serve youngsters with conduct disorders for which funding is still being sought. Another activity was sponsored by a foundation in Stark County, the Education Enhancement Partnership, which allocated \$3 million in 1990 to improve education in the county. The funds are being used in a public/private partnership to assess needed improvements in the county's educational system and to develop plans. The planning process has emphasized the need to look beyond the six-hour school day and work toward strengthening families as well as the need for early identification and intervention for special needs.

o Juvenile Justice: Stark County Family Court and Regional Office of Ohio Department of Youth Services

The Stark County Family Court consists of the Juvenile Court and Domestic Relations Court and has three judges. The Family Court presents its mission as "protection and welfare of the community by providing a network of services and innovative programs for families and youth through cooperation with community agencies in an effort to make juveniles and families more responsible and accountable." To fulfill this mission, the court offers a range of services which are directed at prevention, diversion, and alternatives to institutionalization. These include intensive probation services provided by a probation officer who is skilled in parent effectiveness training; courses in parent effectiveness; in-home detention involving short-term, intensive support and monitoring for offenders as an alternative to incarceration; restitution programs providing supervised work for youth which allows them to compensate victims; and job skills training programs for youth at risk. Services for sex offenders are a priority for the court since there has been a substantial increase in the number of youths involved in sex offenses in recent years. Services include those of a probation officer trained in working with sex offenders as well as diagnosis and treatment offered in conjunction with the CASC. Additionally, prevention programs that stress responsibility and law are provided in the schools for youngsters in third, fourth, and fifth grades. The juvenile justice system in Stark County also includes residential options both provided and purchased by the Family Court.

The Multi-County Juvenile Attention Center, which is located in Stark County, serves as the detention facility for a five-county area. A council of governments was formed by the counties to administer the facility. The regional office of the Ohio Department of Youth Services provides funding for many of the Family Court programs as well as monitoring local service delivery. The Department of Youth Services also assumes custody of youthful offenders upon commitment by the Juvenile Court for felony level offenses, thereby transferring responsibility from the county to the state agency.

o Health: Stark County Health Department, Canton City Health Department, Massillon Health Department, and Alliance Health Department

The health departments in Stark County provide a variety of services available to children and families. Public health nurses conduct physical assessments which include evaluation of growth and development for infants and children through age 18. Childhood immunizations are provided as well as testing for various communicable diseases such as tuberculosis. Diagnosis and treatment of sexually transmitted

diseases is another important function of these agencies, along with follow-up on sexual contacts and education regarding the prevention of sexually transmitted diseases. Increasingly utilized services are testing and counseling for HIV infection and education regarding the transmission and prevention of AIDS. The health departments fulfill a variety of health education functions by providing information and educational programs in many settings including schools.

- o Mental Retardation: Stark County Board of Mental Retardation and Developmental Disabilities (MR/DD)

The Stark County Board of MR/DD was formed in 1968 and provides a "lifetime of services" to people of all ages with mental retardation and developmental disabilities. The MR/DD Board operates seven facilities and provides a range of programs including Early Childhood Intervention, Schools, Adult Services, Family Resources, Case Management, and Social Services.

In 1991, the MR/DD Board adopted a new population definition as required by the state. The new definition expanded the population to be served by the agency by raising the age limit for services from 18 to 21 and by emphasizing substantial functional limitations in determining eligibility. The new definition was presented and discussed at the Cluster meeting.

- o Substance Abuse: Alcohol and Drug Addiction Services Board of Stark County

In 1990, Governor Celeste created a new Department of Alcohol and Drug Addiction Services at the state level. Counties were given the option of having a separate board to plan and oversee substance abuse services or of consolidating this function under their mental health boards. In the majority of Ohio counties, the substance abuse function is combined with mental health under the authority of a single board. Stark County, however, is one of eight counties that elected to have a separate board for substance abuse services.

The Alcohol and Drug Addiction Services Board of Stark County was formed in 1990 with the mission to plan, fund, and evaluate alcohol and drug addiction services in the county. As part of its planning responsibilities, a needs assessment was conducted and a five-year plan for substance abuse services was developed. The Alcohol and Drug Addiction Services Board provides funds to Quest Recovery Services, which is the major substance abuse provider agency serving children and adolescents.

In addition to these major child-serving systems, a number of other agencies participate in the system by providing services to youth and families and through their involvement in the Cluster. These agencies include:

- o Lincoln Way Special Education Regional Resource Center
- o Job Training Partnership
- o Ohio Rehabilitation Services
- o Stark County Prosecutor
- o Early Childhood Collaborative

As in most communities, some agencies within the system assume an especially active role in the organization and operation of the system of care. Other agencies are less active participants and assume a more peripheral role in system activities. Thus, although there are continual efforts to enhance the involvement of all agencies, Stark County has a core group of agencies which are central to system management and service delivery.

VI. SYSTEM OF CARE COMPONENTS

Outpatient Services

The CASC provides a range of outpatient assessment and treatment services; these are considered to be the least intensive treatment option. Outpatient services are offered through offices of the CASC in Canton, Massillon, and Alliance as well as at an alternative school location established for enhanced accessibility to minority families. During fiscal year 1991, outpatient services were provided to more than 700 children and their families. According to data derived from the Global Assessment Scale, approximately 80 percent of the youngsters receiving outpatient services from CASC are considered to have severe emotional disturbances.

Outpatient services typically begin with a multifactored assessment which is conceptualized in two phases: the intake assessment and the clinical assessment. The intake assessment involves gathering basic data in order to determine the reason for admission, presence of life threatening situations, need for a physical examination, preliminary treatment goals, and an indication of what services might be needed. A clinical assessment is completed by the assigned therapist and covers history, current functioning, and strengths and weaknesses in a variety of domains. The assessments conducted by CASC may require multiple sessions and emphasize family and ecological factors. When necessary, psychological and psychiatric evaluations are used to aid in the diagnostic process. Psychological evaluations are used extensively for youth sex offenders referred by the Juvenile Court to assist it in judicial or placement decisions. The assessment process generally culminates in a treatment plan that is developed collaboratively with the parents and youngster as appropriate.

Individual and family therapy also are offered by the CASC. These services typically consist of office-based counseling appointments which take place once or twice a week depending upon the need. The CASC is working towards increasingly providing its outpatient services in natural environments such as the home, school, or community centers. In fact, a goal for 1992 is for 50 percent of all outpatient services to be delivered in such natural settings rather than in CASC offices. Specialized outpatient services are available for youngsters who are dually diagnosed as mentally retarded/developmentally disabled and emotionally or behaviorally disordered. These services involve counseling to children and families as well as classroom consultation. In addition, a variety of groups are offered. For youngsters, group counseling opportunities include social skills groups, sexual abuse groups, and groups on human sexuality. For parents, child management, communication, and assertiveness training workshops are offered as well as groups for parents of preschoolers, parents of teens, teen mothers, single parents, and parents of youngsters with attention deficit hyperactivity disorder.

Outpatient psychiatric services also are offered by the CASC. A child psychiatrist works at the CASC for a total of two and a half days per week, offering diagnostic assessment and consultation. Psychiatric referrals are made for psychiatric evaluation and for prescription and monitoring of medications. In addition, the psychiatrist provides consultation to other CASC programs. Recruitment of child psychiatrists has proven difficult for the CASC, and the wait for a psychiatric appointment may be as long as six to eight weeks. The Cluster is actively recruiting a full-time child psychiatrist to work both at the CASC and the Crisis Center.

While many of the youngsters involved in outpatient services improve, staff acknowledge that many have serious problems and would benefit from more intensive service options. However, the more intensive service options are difficult to obtain due to wait lists. Wait lists are a problem for outpatient services as well; there may be a delay of as much as seven or eight weeks to get an outpatient appointment. In order to serve those most in need, the CASC attempts to prioritize cases based upon seriousness, providing services to youngsters at risk for harm to themselves or others or those returning from out-of-home placements as a first priority. Additionally, limits on length of stay in treatment have been considered as a way to extend services to more youngsters.

Prevention and Early Intervention

An assortment of programs and services included in the system of care fall into the general category of prevention and early intervention. For example, the CASC operates the Peer Listening Program which involves training and supervising adolescents age 15 to 17 to serve as peer listeners. The trained teens offer confidential active listening, support, information, and referral to other adolescents to help them to resolve or explore solutions to their problems. The CASC provides training to groups of 20 to 25 adolescents at a time and focuses on developing communication and helping skills.

Another program is entitled "Friends Can Keep You Healthy" and is a collaborative effort between the CASC and the Canton City Schools. The program involves biweekly support meetings for a small group of elementary school youngsters in several inner city schools. The youngsters considered for inclusion in this program exhibit mild behavioral or socialization problems. It is anticipated that the support meetings will promote more positive feelings among the youngsters toward themselves and others and will reduce the likelihood of more serious problems.

An "At-Risk Dropout Prevention Grant" received by the Canton City Schools also targets high-risk elementary schools in an effort to minimize future mental health and educational problems. The grant funds therapeutic services in the schools on an individual and group basis for students as well as groups for parents. Behavior adjustment classes are a part of this project and involve developing a behavioral plan for a particular child with parent involvement. These behavioral plans are then implemented with the assistance of behavioral adjustment coaches. Additionally, a school pride incentive program provides tangible rewards and incentives for youngsters who follow the rules.

Early intervention activities in Stark County are coordinated by the Early Intervention Collaborative, a multiagency group which coordinates early intervention services for

youngsters from birth to two years. The Collaborative attempts to identify children at-risk for all types of problems at an early age through a centralized resource called the Kids Connection. In addition to early identification, the Collaborative provides developmental information to parents, referrals for services, and parenting classes.

Early intervention activities for children age three to five are coordinated by the local school districts. The Canton City Schools operate preschool programs for at-risk children, including those at risk for emotional disorders, and the CASC provides the mental health component of the community's Head Start Program. The Stark County Board of MR/DD Board also serves a population of children age birth to five who are at risk. For infants and toddlers, a teacher-based service is offered along with individualized occupational therapy, physical therapy, and speech and language therapy as needed. For preschool-age youngsters, an integrated preschool is provided along with several other preschool and day care options for at-risk children.

A unique Preschool Community Services Program is provided to children from birth to five years of age, with a major focus on children with emotional disturbances. The program offers home-based services and consultation in normal preschool settings and provides both clinical and case management services. Until July 1991, these youngsters were served within the Preschool Day Treatment Program which utilized a combined center-based and home-based approach. At this time, the new approach of the Preschool Community Services Program was adopted, and staff was redeployed to attempt to work with these young children in more natural environments including their homes and regular preschools. Following the first full year of operation, the approach is being assessed to determine the continued feasibility of "mainstreaming" these preschoolers. A more specialized setting may need to be reconsidered for some children who present particularly challenging problems and behaviors.

Home-Based Services

The Stark County system of care includes both short-term and longer-term home-based services. The short-term program, Therapeutic In-Home Emergency Services (TIES), was initiated in 1986 as a joint program between the CASC and the Crisis Intervention Center of Stark County. As a result of administrative complications, the program is now operated solely by the Crisis Center, but it remains closely coordinated with the CASC and with other components of the system of care.

TIES is a crisis-oriented program which serves youngsters with serious emotional or behavioral problems who are at imminent risk for out-of-home placement. In order to be eligible for TIES services, the parents must have the desire to keep the family together and be willing to participate in the home-based intervention. The goal of the TIES program is to prevent out-of-home placement by working toward solving problems within the home and family. Like most home-based programs, TIES therapists are available 24 hours a day, seven days a week; the intervention takes place primarily in the home; and visits are scheduled at the family's convenience. Therapists work with only two families at a time, allowing for highly intensive and flexible services for each family. Therapists typically spend an average of six to 10 hours per week with a family; service intensity may reach as high as 20 hours per week with a family depending upon the need. Services are based on an individualized treatment plan for the child and family and include crisis intervention, individual and family

therapy, case management, and a range of support services tailored to each family's needs. The program was started with a service duration of six to eight weeks, but found that this was not sufficient time to respond to a crisis and adequately link the family with ongoing services. As a result, the time frame was expanded to 12 weeks. If families experience further difficulties at some point following completion of a TIES intervention, they may call to request additional services. Program staff visit may the families to provide "booster shots" and continue to remain available by phone for continued support.

The longer-term home-based service program is called Intensive Home-Based Services and is operated by the CASC. The priority target group for this program is comprised of youngsters who are or have been in out-of-home placements for treatment purposes and are not likely to reunify successfully with their families without assistance. Accordingly, the program emphasizes serving children who are returning home from long-term psychiatric care or other residential placements. The Intensive Home-Based Services program is staffed by master's level therapists, each of whom works with a caseload of approximately four families. Caseloads may exceed four if a family is transitioning out of the program and needs a relatively low level of services; caseloads may be reduced if a therapist is working with a family requiring highly intensive intervention. In some cases, two therapists may be assigned to a particular family for either therapeutic or safety reasons such as the potential for violence or abuse. Therapists are available 24 hours a day and work with families for an average of one year, although the duration of services is flexible depending upon the family's needs.

The program is designed to stabilize, maintain, and strengthen families and to assist them to function to their maximum potential within the community. It is described as a "clinical model" which involves an assessment of each family's strengths, weaknesses, and service needs; a treatment plan unique to the identified and prioritized needs of each family; the provision of therapeutic services in a natural and nonthreatening setting that focus on functioning within the family system; and linkages to community resources. In addition to individual and family therapy, therapists perform "case management" functions including helping families to meet basic needs, accessing needed services and resources, and helping families in concrete ways -- in short, doing whatever needs to be done to assist the family. When a family is stabilized, concrete needs are met, and there is a low risk of out-of-home placement, transition plans are then developed to link the family with other ongoing services. At minimum, case managers follow families when home-based services are discontinued. Families experiencing further difficulties following termination may be referred for additional home-based services. The program reassesses these families and attempts to meet their needs either by consulting with the staff currently involved with them (e.g., outpatient therapist or case manager) or by short-term reentry into the program with clearly specified goals. To date, no child served by the program has been returned to long-term psychiatric or residential care.

At the time of the site visit, there were 20 families on a waiting list for the Intensive Home-Based Services program; 10 families currently are waiting for these services. Staff use creative approaches for coping with the high level of demand for services such as consulting with other staff who are working with the family at the time of referral or even doing home visits with outpatient therapists to assist them in working more effectively with particular families.

Day Treatment

The Day Treatment Program in Stark County serves youngsters ranging in age from five to 17. The program is designed to serve children who are experiencing severe emotional, behavioral, and/or social problems to the degree that they cannot be adequately treated with less restrictive therapeutic or educational services. The program is a collaborative effort between the education and mental health systems (the CASC, the Canton City Schools, and the DHS) and is described as psychoeducational. Its educational philosophy and structure is based on the Positive Education Program (PEP), which draws upon the philosophy of Nicholas Hobbs and emphasizes positive achievements as opposed to negative behaviors. A level system is used in each classroom and is adjusted to the maturity, cognitive ability, and social awareness of the students. Multidisciplinary treatment teams provide services to youngsters in day treatment, and a wide variety of specialized services are arranged to meet the needs of individual youngsters. Family involvement and participation is considered an essential element of the program. A summer program is offered for eight weeks for all age groups, and the average length of stay in Day Treatment is approximately 18 months.

The School-Age Day Treatment Program consists of four classrooms which serve a maximum of 28 youngsters from kindergarten through high school. Many of the youngsters have been hospitalized at Sagamore Hills or are being diverted from such a placement; more than 70 percent of the youngsters in Day Treatment have been in a hospital or residential treatment center at some time. The vast majority have had multiple school placements, and many are involved with the juvenile justice system. Thus, the Day Treatment Program serves a group of youngsters with extremely serious problems, comparable to the population once served by the state hospital and other psychiatric treatment settings.

In order to be eligible for the program, a youngster must be age five to 17; exhibit severe behavioral, emotional, and/or social disorders; be eligible for enrollment in a Severe Behavior Handicapped Unit as defined by Ohio Department of Education criteria; and be unable to function in a public school setting among other criteria. A structured level system is used in each classroom emphasizing positive reinforcement, and a multidisciplinary team provides a range of services and support to the youngsters and their families. Mental health services include individual, group, and family therapy. A parent group assists parents by providing information on management techniques and an opportunity for mutual sharing and support. In addition to the mental health and educational services which form the core of the program, the youngsters receive extensive case management services, social skills groups, recreational services, speech and language programming, and other related services. A psychiatrist works with the program for approximately six to eight hours each week providing consultation to staff, observing in classrooms, and seeing individual youngsters. Approximately one-third of the children in the program are on some type of medication.

While the average length of stay is 18 months, the program is flexible and willing to make decisions based upon the needs of each individual youngster. An attempt is made to move youngsters into more normalized educational and treatment settings if possible. However, if it is clear that an extended stay in the Day Treatment Program is best for a child, the program will allow the youngster to stay. Transitions back to regular public schools are handled gradually, beginning with a visit and tour. Reintegration may begin with attendance at the school one day per week, with gradual increases over time. Case management and

outpatient mental health services are continued both during and following the transition out of Day Treatment.

The longest waiting list for the Day Treatment Program is for older adolescents, the age group which is also considered the most difficult to serve. The program is attempting to provide additional vocational programming and independent living skills training to better serve this age group.

At the time of the site visit, day treatment services included a Preschool Day Treatment program accommodating a maximum of 24 children age two and a half to six years. The program served all of Stark County, with transportation provided by Goodwill and it operated five days a week, six hours per day. The admission criteria for the program specified that preschoolers exhibit severe behavioral, emotional, or social problems; that they did not benefit from previous services in outpatient mental health or other community settings; and that they have had a complete medical screening. The program utilized a highly structured level system coupled with school readiness activities, socialization groups, and individual therapy when appropriate. Parents were closely involved in all aspects of the program. In addition to home visits by staff, parents come into the program to observe their children, spend time with therapists, attend family therapy session, and accompany youngsters on field trips.

A unique aspect of the Preschool Day Treatment Program was the development of a combined center-based and home-based approach for the majority of youngsters. One group of preschoolers attended the five-day school program. Two additional groups were involved in an intensive preschool home-based program. This approach was developed in recognition of the difficulty in translating gains in the treatment setting to the home environment. It was decided to reduce the amount of time children spent in the center to two days per week and to provide a therapist, called an "early childhood interventionist," to visit families at home once or twice weekly for one to two hours depending upon the family's needs. The interventionist worked with families on child development, behavior management, nutrition, homemaking skills, and obtaining needed services and supports. The success of this combined center and home-based approach led to the decision to transform the Preschool Day Treatment Program into the Preschool Community Services Program. Staff were redeployed to work with these youngsters in more natural settings including their homes and regular preschools. The interventionists provide clinical and case management services to the children and their families as well as consultation to the preschools that the children now attend. The new approach, adopted in July 1991, currently is being evaluated with particular attention to the feasibility of mainstreaming these preschoolers with emotional and behavioral disorders. Consideration may need to be given to reestablishing a more specialized setting for some youngsters who present particularly difficult challenges.

Crisis Services

Mental health crisis services in Stark County are provided by the Crisis Intervention Center of Stark County, a free-standing, nonprofit agency. The Crisis Center is funded primarily by the Mental Health Board and serves as a county-wide emergency services system. The agency characterizes its purposes as providing crisis intervention in the community, decreasing the need for hospitalization, and assuring appropriate use of community resources.

The Crisis Intervention Center is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO).

The Crisis Center was started in 1970 as a crisis telephone hotline staffed by volunteers. Although volunteers are still utilized for the hotline, the Center now relies on staff who are specialized and highly skilled in handling crises. The agency recruits staff who are well suited for crisis work and boasts an average staff tenure of about 7.5 years, a noteworthy accomplishment in the area of crisis services where burnout is prevalent.

The Crisis Center offers a range of crisis services. Telephone crisis services are offered through a 24-hour hotline answered by staff with the assistance of volunteers. Volunteers receive 48 hours of classroom training as well as close supervision to prepare them for this role. Through the hotline, the Crisis Center provides after-hours phone coverage for all contract agencies of the Mental Health Board and for other agencies as well. The CASC, the three adult mental health centers, and the substance abuse treatment agency in the county all rely upon the Crisis Center for after-hours telephone coverage. The DHS child abuse/neglect report line and Parents Anonymous are among the other agencies and groups utilizing the Crisis Center's telephone crisis services. The Crisis Center has estimated that approximately 20 percent of its calls are related to children.

Face-to-face crisis services also are provided, primarily on an outreach basis. The philosophy of the agency involves going out to where the crisis is occurring in order to intervene most effectively. The Crisis Center estimates that more than half of its outreach services involve children and adolescents and their families. Individual staff members perform outreach services 24 hours a day; a team which includes a psychiatrist may respond when hospitalization is a potential disposition. Walk-in crisis services also are available at the Center, along with a number of groups such as a treatment group for men involved in domestic violence, a group for persons who have lost someone through suicide, and a support group for people with HIV or AIDS and significant others.

In cases involving children, the Crisis Center works closely and cooperatively with the CASC. Home-based therapists and case managers are available 24 hours a day and can be contacted if crises involve their clients. In other cases, particularly in serious clinical emergencies, the Crisis Center's staff handle the crises directly. Where there is a question of psychiatric hospitalization, the Crisis Center contacts CASC staff members who are responsible for the screening, assessment, and procedural arrangements. In order to ensure continuity of services, the Crisis Center prepares a list of clients with whom they have had contact for each of the participating agencies. This list is faxed daily to each agency including the CASC. If the client has a case manager, the crisis worker calls the case manager to provide information about the crisis contact.

Another type of crisis service is observation beds at the Crisis Center which provide an opportunity for brief respite, further observation, and stabilization. At the time of the site visit, only two such beds were available for both adults and children, and there was universal agreement that two beds for the entire county was insufficient to meet the need. In fact, respondents agreed that a missing component in the system of care is some type of short-term, crisis residential option for children. In response to this need, the Mental Health Board and Alcohol and Drug Addiction Services Board are providing funds for an expanded capacity

for crisis residential services. The third floor of the Crisis Center is undergoing renovation to serve as a short-term residential crisis option with 12 beds. A separate section with four beds has been designated to provide short-term crisis placements for children and adolescents. The new crisis residential services should be operational by August 1992.

Child and Family Advocacy Program

In response to the growing problem of child sexual abuse in the community, a working coalition of agencies formed in 1986. The coalition included DHS, the Juvenile Court, the Mental Health Board, the CASC, the Crisis Center, Junior League, law enforcement agencies, and others and resulted in a plan for a program to provide assessment and therapeutic services related to sexual abuse. A grant application was prepared by the Crisis Center, and funding was received from the Victims of Crime Act to initiate the program; the CASC received additional monies to supplement the program. Thus, the Child and Family Advocacy Program was started in 1987 as a joint program of the Crisis Center and CASC.

Due to complex administrative problems, the funding was ultimately combined and the program unified under the administrative auspices of the CASC. Currently, the Child and Family Advocacy Program conducts assessments of sexual abuse situations including psychological evaluation of the child, assessment of the ability of a child to testify, veracity of allegations, potential effects of a court hearing on the child, and child placement issues. Staff provide therapeutic services including individual and family therapy for as long as necessary. Group treatment also is offered including a teen support group and a mothers group. Services provided by the program are limited to nonoffending family members with offenders referred to other treatment resources. In addition, the program advocates for the child with other agencies, including attending regular meetings with the prosecutor handling the child's case to assist in decision making at each stage. The program also has an educational function, conducting seminars and preparing brochures and other materials to assist teachers and other agencies to identify and respond appropriately to situations which may involve sexual abuse.

Substance Abuse Services

The primary provider of substance abuse services to children and adolescents in Stark County is Quest Recovery Services. Quest's major service is its Intensive Adolescent Outpatient Treatment Program, which consists of daily programming from Monday through Friday from 4:00 P.M. to 8:00 P.M. for a period of more than four weeks. This program provides individual counseling, family and group therapy, personal growth/self-awareness activities, refusal skills, lectures and speakers, videos, group discussions, and access to medical services. Following this initial intensive program, a 12-week continuing care program is provided which offers emotional support to adolescents and their families and encourages continuing personal growth. A complete assessment, including a physical examination, is required prior to admission to the program. In addition to the Quest's services, a number of area hospitals offer substance abuse treatment on an inpatient basis.

Youth Sex Offenders Program

The Youth Sex Offenders Program is a joint program of the Stark County Family Court and the CASC. The program focuses on adolescents who are already adjudicated adolescent sex offenders or youngsters with problems severe enough to place them at high risk for this outcome. The services begin with a diagnostic assessment, a major component of which is a community risk assessment used to determine the safety of working with the youngster in the community. If the risk is deemed too high, a secure treatment setting is sought. Unfortunately, there is no secure treatment program for sexual offenders within Stark County.

For those adolescents who can remain in the community, the program provides counseling and psychotherapy on an individual and group basis. A group for youth sex offenders is co-led by a mental health therapist from the CASC and a probation officer, both of whom have received highly specialized training in this area. The program is seen as an alternative to more costly and restrictive institutional placements and serves approximately 25 children per year. As of fiscal year 1992, none of the youngsters have committed additional offenses while involved in the program.

Respite Services

The major provider of respite services is the Tri-County Easter Seals Society. Easter Seals offers in-home respite utilizing trained adults as providers, out-of-home respite in the provider's home, and emergency respite. The trained respite providers provide families with a much needed break from the physical and emotional demands of caregiving. In the past, Easter Seals respite services were available only to individuals with mental retardation or developmental disabilities. Respite services have been expanded to serve families of youngsters with serious emotional disorders and adults with severe mental disabilities. For children, arrangements for respite services are handled on an individual case basis and typically are purchased by the Cluster or the CASC. Respite providers with Easter Seals receive over 40 hours of specialized training related to the needs of developmentally disabled and/or mentally disabled populations. Easter Seals is working with the CASC to develop a training package for respite workers that is specifically geared toward working more effectively with children who have emotional disturbances.

In addition, a list of independent on-call support persons has been prepared by the CASC. These persons can be contacted as needed to provide respite or other types of support to children and families. A goal is to computerize this list of on-call support persons and make it available to all Cluster participants. In addition, a training program for these support persons is being developed.

Residential Services

Youngsters requiring treatment in residential settings have access to a number of placement options. Ohio Mentor provides some therapeutic foster care services in the county, but these have primarily been targeted for children with mental retardation. The Stark County DHS operates a system of group homes which serve youngsters with emotional or behavioral disorders. Residential treatment options used by the Stark County system of care are all

located outside of the county and include such facilities as Berea Children's Home, Marycrest, Parmadale Family Services, and Beechbrook, all located in Cleveland, and Smithville Boys Village in Wooster. When a Stark County youngster is in any of these facilities, a liaison from the county is assigned to work with the child and the therapist to ensure that high quality services are being provided. An attempt is made to visit each child in out-of-county placement at least once per month.

Inpatient psychiatric services are provided by Timken Mercy Hospital which is located in Stark County and has a specialized adolescent psychiatric unit. Aultman Hospital, also located within the county, does not have a separate children's unit but does on occasion admit adolescents over age 16 to its psychiatric unit. A psychiatric unit for children and adolescents also is available at Akron Children's Hospital Medical Center, approximately 30 miles away in neighboring Summit County. Sagamore Hills, located in Cleveland, is the state psychiatric hospital for children. The hospital serves adolescents ages 12 to 18 who are harmful to themselves or others. The hospital has been significantly downsized, however, and the state plans to transform it into community-based programs. Residential and psychiatric hospitalization are paid for with Cluster funds unless there are other sources of funding, such as Medicaid or insurance, which are drawn upon first.

System Needs and Gaps

Stark County has systematically built the service array included in its system of care. In particular, the community has attempted to increase the array of intensive, nonresidential services such as home-based services and day treatment. The expressed purpose of creating intensive, nonresidential service options has been to reduce the need for out-of-home and out-of-county placements. Despite noteworthy progress in building the array of services included in the system, service gaps remain. There appears to be widespread agreement that three services in particular are critically needed.

The first of these services is therapeutic foster care. At the time of the site visit, some therapeutic foster care services were purchased, primarily by DHS, from several private agencies. Many of these treatment homes were not within Stark County, and there was a great deal of skepticism about the quality and intensity of the treatment services they provided. As a result, therapeutic foster care was not utilized to the extent possible as a less restrictive residential treatment resource for the Stark County system of care. At the time of the site visit, the participating agencies were considering how the capacity to provide therapeutic foster care should be developed in Stark County and which agency should take the lead role. Options under consideration included continuing to purchase therapeutic foster care, but expanding such resources within the county and enhancing the quality of services, or selecting one or more agencies, such as DHS or the CASC, to develop therapeutic foster care services for Stark County. Ultimately, the Cluster made the decision to approach a private provider of other residential services (groups homes and regular foster care) with the possibility of developing therapeutic foster care services for youngsters served by the Cluster. The provider, Pathway, responded favorably and worked with the Cluster to develop plans for therapeutic foster care services. Together, the Cluster and Pathway approached the Stark and Deuble Foundations for financial support and received \$50,000 in grants for program development. A coordinator for the program has been hired, and recruitment and training of treatment parents is planned for the summer of 1992. The Cluster plans on purchasing

therapeutic foster care services from Pathway on an individual case basis; access to the therapeutic foster care beds will be restricted to the Cluster process.

Respondents indicated that a second priority need for the county was for a crisis residential resource for children. As noted, the Crisis Center had two crisis beds on its premises which allowed for overnight support and observation. However, these beds were shared with the adult service system and were much in demand. In many crisis situations involving children and adolescents, therefore, there was no resource for a short-term residential placement for crisis intervention and stabilization. The lack of such a resource resulted in the use of hospitals and other settings, such as the Attention Center or DHS shelter, for crisis stabilization purposes. There was considerable agreement that the addition of a short-term crisis residential program of some sort would provide a more appropriate and effective resource for youngsters.

Similar to the progress achieved in addressing the need for therapeutic foster care, the community has made progress in filling this gap as well. A new crisis residential program operated by the Crisis Center is slated to open in August 1992, and four beds in a separate area have been reserved for children and adolescents who require a short-term placement for crisis intervention and stabilization purposes. In addition, the CASC has identified a cadre of on-call support persons who can be enlisted to provide support during a crisis in youngsters' homes or in other settings. Further, two providers (Mentor and Easter Seals) now have the capacity to provide short-term crisis respite services in therapeutic foster homes for up to 90 days. Finally, the Cluster has decided to lease a two-bedroom apartment for use in crisis situations. The apartment will be staffed as needed with on-call support persons, and the CASC will provide professional staff to work with the children and their families.

A third need mentioned by many respondents is services for sex offenders. The Stark County system of care has been struggling to determine the types of services that would be both secure and effective in treating this growing population. The dual mission of such services would be to protect the community while at the same time attempting to rehabilitate the youthful offender. The system of care does include an outpatient program to work with sex offenders, but this does not meet the needs of those youngsters who present some risk to the community and who require a more secure treatment environment. In response to this need, the Cluster organized a work group on sex offenders. The work group planned to consult with experts in the area of youthful sex offenders for assistance in conceptualizing and designing appropriate services for these youngsters.

In addition to these priority system needs, respondents noted a number of other service gaps. These include:

- o Expanded capacity in all service components (e.g., outpatient services, home-based services, day treatment, and case management) to more adequately meet the needs.
- o Transition services for older adolescents including vocational services and independent living services.
- o Additional services in outlying areas.

VII. SYSTEM LEVEL COORDINATION MECHANISMS

Context for Interagency Collaboration

As might be expected, the system of care in Stark County evolved from a history of interagency collaboration around the needs of children. More than 15 years prior to the executive order requiring clusters, the executives of the child-serving agencies in the county began meeting as a group. While these early efforts to coordinate services were not nearly as extensive or systematic as they are today, the groundwork for collaborative efforts was in place well before the state mandates. In addition to the attempts of the agency executives to work together and support one another, there are several examples of interagency endeavors related to services for children and adolescents. Included among these are the following:

- o Child and Family Advocacy Advisory Committee - At the urging of the county prosecutor, a multiagency coalition was formed in 1986 to improve both services and interagency coordination for victims of sexual abuse. A major result of the interagency effort was the development of the Child and Family Advocacy Center which provides a range of therapeutic and support services to children who have been sexually abused. The coalition has continued to exist in the form of an advisory committee which meets periodically to guide the Center's services.
- o Sex Abuse Task Force - This multiagency group meets weekly and coordinates the involvement of the various agencies in specific child abuse cases, with a primary focus of sexual abuse. Beyond its role in planning and coordinating the prosecution and treatment of individual cases, the task force has had a significant impact at the system level. For example, a protocol for use in sexual abuse cases was developed, and the task force has clarified and reduced overlap of the roles of different agencies in investigations.
- o Day Treatment Advisory Committee - This is a program committee of the CASC Board of Directors and is comprised of parents, a physician, a child advocate, and representatives of the Canton City Schools and other child-serving agencies. The committee meets quarterly to review programmatic issues and make recommendations regarding the operation and continued development of the Day Treatment Program.
- o School and Agency Advisory Council - Representatives of all of the school districts in Stark County and the human service agencies comprise the School and Agency Advisory Council. This group meets three times per year and is chaired by the CASC's Coordinator of Consultation, Education, and Prevention. The primary purpose of this council is to provide information about new services and changes within the various agencies. The council fulfills a valuable educational function within the system of care by apprising schools and human service agencies on a regular basis of what services are available and how to access services.

Stark County Interagency Children's Cluster

In the context of this tradition of interagency collaboration to address services for children, the Stark County Interagency Children's Cluster was organized in 1984 at the time of the Governor's executive order. Comprised of the major child-serving agencies, the Cluster's initial mission was limited primarily to case review. A statement of purposes and objectives for the Cluster that was developed in 1985 clearly reflected this focus on individual cases of multineed youngsters. Stated functions included:

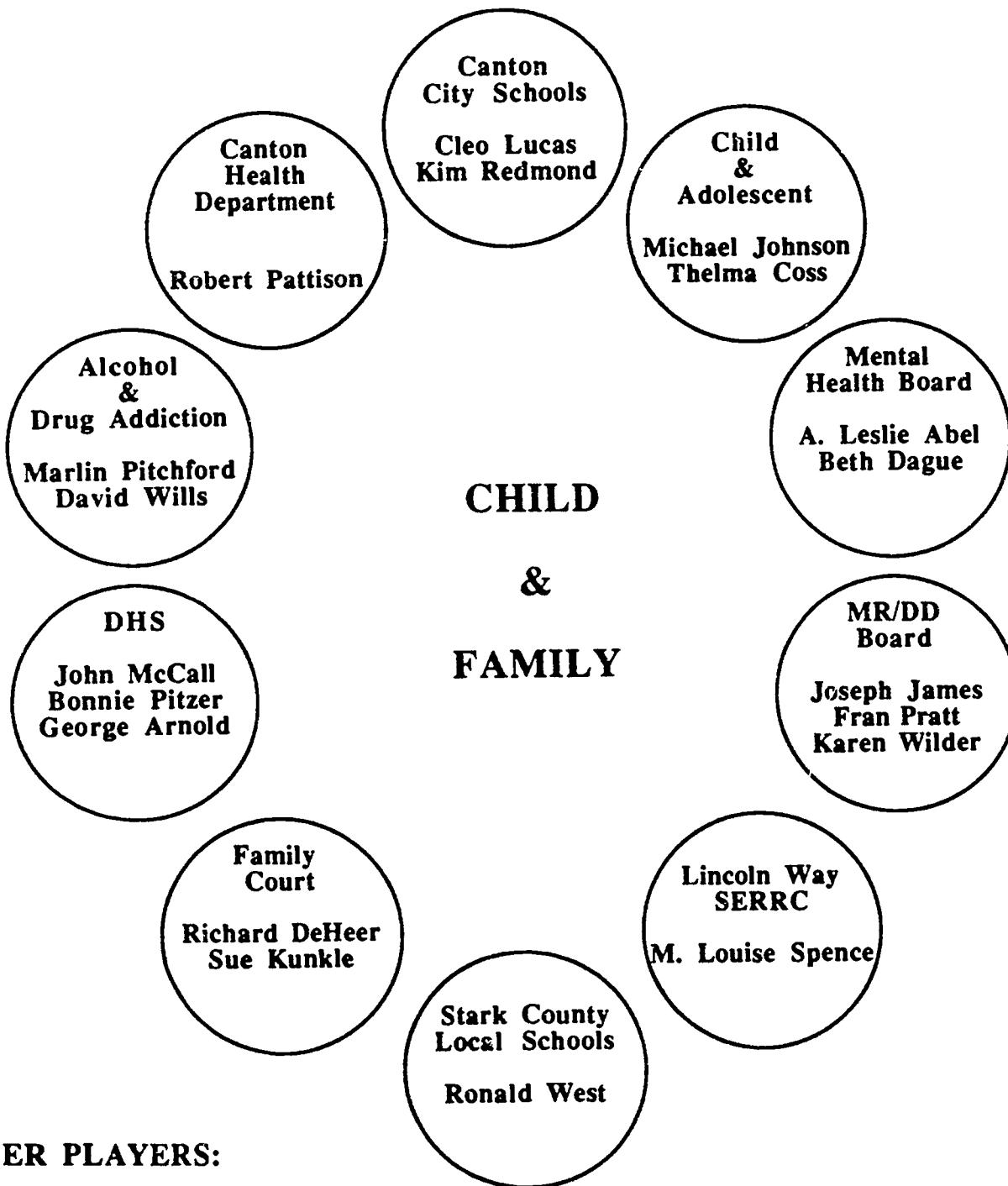
- o Review of specific individual cases referred by Cluster members,
- o Identification of an agency to provide case management,
- o Development of an individual written service plan,
- o Oversight to ensure timely and coordinated service delivery, and
- o Ongoing monitoring of cases brought to the Cluster.

Since its inception, both the structure and mission of the Cluster have changed substantially. The membership of the Cluster has broadened to include not only the major child-serving systems but a wider range of agencies and providers serving children and families. The diagram on the following page reflects the current membership of the Cluster. Concurrently, the mission of the Cluster has clearly evolved to focus on system level issues related to the development, financing, coordination, and evaluation of the system of care. Since 1989, a series of retreats with an outside facilitator have been vital in shaping the Cluster's development. The retreats have resulted in agreement among Cluster members on issues ranging from the vision and principles for the system of care to mechanisms for blended funding of services for multineed youngsters. Thus, it is the Stark County Interagency Children's Cluster that serves as the structure for system level coordination for the system of care.

The movement of the Cluster toward a system focus has not negated its role in case review. To the contrary, the community has designed a three-tiered structure to enable both client-level and system-level coordination functions to be fulfilled. At the direct service level, the Creative Community Options process is used to bring together all service providers involved with a child and family to participate in strengths-based assessment and treatment planning process. For cases which require problem-solving at a higher level, the second tier is the ACCORD (A Creative Community Options Review Decision). The ACCORD is a standing committee of middle-level managers from each of the major child-serving agencies and is considered to be a subcommittee of the Cluster. It reviews cases, problem solves, and monitors treatment for referred youngsters. If consensus on a particular case cannot be reached at the ACCORD level, the case may be referred to the Cluster for resolution. The ACCORD also is in a strategic position to identify service gaps and feed information about the functioning of the system of care to the Cluster. Both the Creative Community Options process and the ACCORD are described in greater detail in the following section, Client Level Coordination Mechanisms.

The third level of coordination is the Cluster itself, also referred to as the Administrative Cluster. It is this level that is comprised of the top executives of the participating agencies. Cluster meetings are held monthly, with responsibilities for chairing the Cluster rotating every six months. At the time of the site visit, the Executive Director of the Mental Health

Stark County Interagency Children's Cluster



OTHER PLAYERS:

- Early Childhood Collaborative
- Job Training Partnership
- Stark County Health Department
- Ohio Rehabilitation Services
- Stark County Prosecutor

Board was serving as chairperson of the Cluster. A Cluster meeting, held during the site visit began with a review of minutes. The second agenda item was presentation of new cases, however there were no new cases for Cluster consideration on that particular date. The group proceeded to hear updates on cases previously considered. One of the cases discussed involved a 15-year-old male sex offender placed at Sagamore Hills. The youngster reportedly was not benefitting from an intensive treatment program at Sagamore (the One-to-One Program) and was continuing to engage in inappropriate sexual behavior. Because the youngster had been adjudicated for rape and had prior offenses, the group agreed that a secure treatment setting was indicated. However, no one at the meeting was aware of a secure setting which offers treatment for young sexual offenders, and responsibility was assigned to investigate potential treatment resources.

The major portion of the Cluster meeting was devoted to consideration of system level issues. These included:

- o Plans for an Early Childhood Center - The group discussed plans for the creation of an early childhood center which would combine a variety of programs and resources for young children and their families. As envisioned, the center would house and integrate services including day care for normal and handicapped children, early childhood classes provided by the schools, and classes for at-risk children sponsored by the county. The Education Enhancement Partnership is continuing to work on implementing this concept.
- o Rehabilitative Services Commission Initiative - The Cluster discussed plans to write a grant through the education system to access funds offered by the Rehabilitative Services Commission. The group agreed that the grant application should be for innovative uses of rehabilitation funds for Cluster children. While the initial amount of the grant would be small, the group saw this as an opportunity to make inroads with the Rehabilitative Services Commission and to begin to provide vocational services to youngsters. The Cluster also discussed the possibility of inviting a representative of the Rehabilitative Services Commission to sit on the ACCORD and determine how the rehabilitation agency might contribute to the service plans of individual youngsters. Potential services might include tutoring, job coaching, preparation for employment, training, and work adjustment services. The county was successful in obtaining this grant which was used to purchase job coaches and employment services for three youngsters. In addition, the Rehabilitative Services Commission now participates on the ACCORD.
- o Task Force on Sexual Offenders - The Cluster discussed establishing a task force on the needs of sexual offenders and debated the composition of such a task force. The two primary approaches considered were to create a task force comprised of clinical experts in this area or to build the task force with decision makers who would focus more on system issues. The Cluster decided on a task force of decision makers focusing on system gaps and system coordination issues; the task force could bring in clinical experts on sex offenders as needed. Following the discussion, volunteers were taken and the task force was formed. One action resulting from the task force was the issuance of requests for proposals from local providers to provide community-based services to three youth sex offenders who were in Sagamore Hills. As there was

limited interest among providers in serving these youngsters, the task force continues to work to find viable approaches.

- o Cluster Coordinator Position - The Cluster discussed the possibility of obtaining funds to support a paid cluster coordinator position. Plans to approach the County Commissioners for partial funds for this purpose were finalized; additional contributions for this position could potentially come from the individual member agencies.
- o Task Force on Organizational Structure - The Cluster established a task force to explore potential legal structures to coordinate the system of care. The task force was to be chaired by the Children's Coordinator of the Mental Health Board and was charged with pursuing various organizational options and reporting back at a subsequent Cluster meeting. A 501(c)(3) corporation, a council of governments (COG), and a division of an existing agency were among the options under consideration for a legal operating structure. At the time, it was felt that a more formalized interagency entity such as a corporation or a COG might be necessary in order to apply for grants, hire a cluster coordinator, or expend monies from a pooled source. A legal entity also might serve as the lead agency for creating new services, such as therapeutic foster care or services for sex offenders, and could operate joint services. At the time, a COG was the structure receiving the most serious consideration, and the member agencies agreed to make appropriate inquiries as to whether they could participate in a COG.
- o Fiscal Strategy for Pooled Resources - A major issue discussed at the Cluster meeting was the proposal to blend agency resources to create a fund to be used for Cluster children. This issue had been examined at length during a retreat held in January 1991, and agencies had agreed to determine whether they could participate in such an arrangement. Some agencies expressed concerns about the legality of such noncategorical funding, and there was also some concern about placing unrestricted funds at the discretion of the Cluster. At the time of the site visit, the Cluster was attempting to develop a formula which would specify the percentage of participation of the various agencies in a resource pool.

It is interesting to note that the latter three issues discussed at this Cluster meeting cover critical issues that the Stark County Cluster has faced in recent years. The need for a cluster coordinator has been raised repeatedly and is based upon the contention that a full-time position is needed to coordinate the activities of the system of care. The Stark County Commissioners were approached for partial funding for such a position, and there was considerable discussion of individual agency contributions to further support a coordinator. Ultimately, the addition of a Children's Coordinator to the staff of the Mental Health Board diminished the urgency of hiring a cluster coordinator. The Children's Coordinator naturally began to assume many of these responsibilities and eventually was formally recognized as fulfilling the cluster coordinator's role. Funds were obtained from the State Level Cluster to support 50 percent of the Children's Coordinator's salary in recognition of the coordinating functions she assumed for the local Cluster.

With respect to an organizational structure, the Cluster ultimately determined that it could function as a cluster and did not necessarily require an alternative legal structure in order to continue the development of the system of care. As a result, the Cluster has not pursued the formation of a nonprofit corporation or a COG but rather has continued to function and evolve in its current organizational form. Formation of a COG or another type of legal entity has not been ruled out for the future.

Perhaps the most significant development in the evolution of the Cluster was the adoption of a formal agreement committing funds from four core agencies to the care of multineed and multisystem children and families. The agreement, signed in January 1992, blends \$750,000 in funds from the DHS, the Mental Health Board, the MR/DD Board, and the Alcohol and Drug Addiction Services Board. The agreement further stipulates that each core agency will pay a proportion of the cost of services provided to each multineed child based upon pre-established percentages, and that other Cluster agencies may contribute on a case-by-case basis. Thus, the Cluster was successful in implementing a fiscal strategy for pooled resources to support services for multineed youngsters. It is anticipated that additional agencies, such as the Canton City Schools and the Stark County Family Court, will contribute to the blended funds in fiscal year 1993.

The Cluster's priorities for 1992 include:

- o Development of therapeutic foster care services.
- o Development of a multisystem case management training program for case managers and supervisory personnel from all systems involving 20 to 24 hours of training over six to eight months.
- o Development of a system for case managers to rotate through multiple child-serving agencies ("Walk a Mile in My Shoes").
- o Development of client tracking and client outcome monitoring tools to review youngsters served by the Cluster in order to determine if services are active and ongoing and if youngsters are being maintained in or moved to less restrictive settings.
- o Development of school-based mental health services by deploying outpatient staff into school settings to provide services.
- o Development of aggressive case finding to identify children in the child welfare system who are in need of mental health services.
- o Development of a public/private partnership including Cluster agencies, private providers, and local foundations for the purpose of creating greater community ownership and awareness of the needs of children and families and developing strategies to address these needs.

The functioning of the Stark County Interagency Cluster is considered to be highly effective. Respondents reported that the Cluster has made steady progress toward a more integrated approach and has steadily broken down the barriers between the various child-serving systems. One of the ways that progress is evident is that Cluster members spend much more time discussing what is needed as opposed to who will pay. The significant progress achieved by the Cluster has been attributed largely to the perception of children as Stark County children rather than children with a particular type of label. This joint ownership and shared responsibility for troubled children has created an atmosphere of cooperation. Despite

remarkable progress in creating and coordinating a system of care, the Cluster has encountered a number of troublesome barriers:

- o Balancing the mission of the system of care with the mission of individual agencies - Each Cluster agency must report back to its own board of directors. Agency boards typically are fiscally conservative and may be reluctant to make changes in agency budgets to accommodate Cluster needs and priorities.
- o Dependence upon key individuals - Respondents indicated that the effective functioning of the Cluster may be dependent, to some extent, on the participation of key individuals who have set the tone for collaboration and provided leadership. If these or other Cluster representatives leave their jobs, a difficult process of reeducation and reorientation of new individuals will be necessary.
- o Categorical funding - Categorical funding has been a barrier which has reportedly hampered the Cluster's ability to use funds to address system gaps and priorities. The Cluster has had to seek creative ways of blending funds and accessing funding sources in order to continue to develop the system of care in the desired directions.
- o Differences in approach among agencies - Various agencies, by definition, have different perceptions of problems and different approaches to address them. For example, some agencies may stress keeping children at home, while others may lean more towards removing children in situations with perceived risk. Respondents emphasized the necessity of dealing openly with these differences in perception or approach in order to resolve disagreements and work together effectively.
- o Reluctant or uninvolved agencies - As in any community, some agencies are less active participants in the system of care. In addition, some agencies have not been involved in Cluster activities. While the Canton City School system is an active Cluster participant, the other school districts in the county have been involved only in isolated cases. Respondents indicated that efforts are needed to involve the other schools districts more systematically in the system of care. The strategy used to "hook" uninvolved agencies has generally been to demonstrate what they stand to gain by participating. For example, a local school district can be shown how much is spent on an out-of-district placement and that working with the Cluster potentially could avert the need for some these placements. This may create a greater incentive for more active participation in the Cluster and system of care.

VIII. CLIENT LEVEL COORDINATION MECHANISMS

The client level coordination function in the Stark County system of care is fulfilled by two primary approaches -- using specialized mental health case managers at the CASC and assigning a lead case manager from the most logical provider agency. The mental health case management program at the CASC is staffed by 13 case managers, most at the bachelor's degree level, and two supervisors who are organized into two teams. Each case manager carries a caseload of 15 to 20 cases, although case managers reported that the ideal caseload

size should be 10 to 12. Case managers are available 24 hours a day during the work week, with a pager system used to contact case managers after working hours when necessary. On weekends and holidays, one member of each team is on call to respond to crises. Case managers may submit a "crisis plan" for a particular family which advises on-call staff as to how to handle a potential crisis.

Considerable attention was given to defining the target population for mental health case management services since it was clearly not possible to serve all youngsters in need with the resources available. The target population was therefore defined as youngsters up to age 18 who are seriously emotionally disturbed and:

- o Are hospitalized in a psychiatric setting as part of the public mental health system
- o Are placed in a secure psychiatric setting through the public mental health system
- o Are placed in a residential treatment facility
- o Are placed in Cluster therapeutic foster care
- o Are placed in other therapeutic foster care
- o Are at serious risk of out-of-home placement
- o Are enrolled at the mental health Day Treatment Program at the Shipley Center
- o Score below 50 on the Global Assessment Scale
- o Are receiving more than eight units of counseling, psychotherapy, or crisis intervention services per month

Some youngsters may be eligible for mental health case management services, but if they are receiving case management services through another agency, might not have a mental health case manager from the CASC. While there often is a waiting list for mental health case management services, an attempt is made to respond to emergent cases promptly. The program currently services approximately 300 youngsters.

The role of the mental health case managers includes the functions typically associated with case management including:

- o Assessing the child's and family's strengths and needs,
- o Planning with the family and other service providers to develop a service plan,
- o Linking and referring the child and family to needed services and resources,
- o Helping families to meet basic needs,
- o Advocating for the child and family's point of view,
- o Coordinating services with schools and other agencies,
- o Monitoring the implementation of the service plan and progress, and
- o Providing support and crisis intervention.

Case managers characterize their role as working with the child and family to assess strengths and needs and to explore resources to access treatment in the least restrictive, most normative setting possible. This characterization reflects the commitment of the case management program to maximizing the use of community-based alternatives to hospitalization and other residential treatment placements. Additionally, case managers report that their activities are all directed toward "empowerment" of the child and family.

The focus of case management services moves beyond the referred child and involves working with the entire family. This often entails extensive work with other children within the family and with extended family members. Case management services are not interrupted when the child is placed in a hospital, group home, or other out-of-home setting. Rather, the case manager continues to work closely with the child, the family, and the treatment setting. While case managers provide high levels of support and supportive counseling, they do not see their role as providing "therapy" per se. Children and families requiring psychotherapy are referred to professional therapists at the CASC or in the private sector.

Mental health case managers work closely with other child-serving agencies on a formal and informal basis. Through service planning meetings, staff from other agencies participate in the development, implementation, and monitoring of service plans. Frequent personal and phone contact is maintained with staff from other agencies to ensure that services are being delivered as planned, to coordinate work with families, and to adjust service plans and approaches as needed. The personal relationships that develop between the case managers and staff from other agencies facilitate this process. While case managers do not necessarily have the authority to compel agencies to provide services, they appear to use these alternative strategies effectively to maximize the cooperation and participation of other agencies.

Respondents indicated that some staff from other agencies, and even staff within the CASC, do not fully understand the role of the case manager and may have unreasonable expectations. For example, some staff may perceive the case manager as a "gofer" or taxi driver rather than a coordinator of care who is probably the person most familiar with the family's strengths and needs. Case managers work closely with staff throughout the system to clarify the role of the case manager within the system of care and to demonstrate the significance of this service.

Case managers have access to flexible funds, \$40,000 in fiscal year 1992, with plans to expand the amount of flexible funds available for wraparound services in the future. These funds can be accessed through specific purchase requisitions or through cash advances and can be used to meet identified needs for a child and family. Flexible funds have been used for taxi fares, school supplies, scout memberships, music and karate lessons, camp, after school activities and classes, food, clothing, cleaning and household items, and repairs. The funds also can be used for utility bills and rent, with agreements from clients for repayment. Cluster funds also can be accessed by case managers to purchase services and supports that would keep a child at home.

A number of advantages to using a specialized mental health case management approach were identified by respondents. Specialized mental health case managers develop considerable expertise in working with children with emotional disorders and their families as well as in-depth knowledge of the services and resources available in the community. Further, they become skilled at providing crisis intervention and community support to children and families and advocating on their behalf.

A second approach to client level coordination used in Stark County involves assigning a lead case manager to a child and family from the most logical, or most involved, provider agency. Typically, the most logical agency is determined by the child and family's primary area of

need. Thus, a child with an emotional disorder may have a case manager through the CASC case management program or may have a lead case manager from the DHS, MR/DD, Juvenile Court, or another agency depending upon the circumstances. Respondents reported that this approach also can be effective. The use of multiagency service planning meetings and frequent contact among involved agencies ensures that staff work together and services are coordinated. The advantages to assigning a lead case manager from a service agency are that the case manager will most likely have in-depth knowledge of the child's primary area of need and of the resources available in that area. Potential problems may arise, however, from turf issues or from differing perspectives about service provision. If, for example, the lead case manager focuses on one area of need to the exclusion of others, then the family will not receive a comprehensive service package. Respondents asserted that either approach to case management can be effective if the entire system of care is committed to a comprehensive, client-centered, multisystem approach to service delivery.

Service planning meetings involving representatives of multiple provider agencies are an essential element of client level coordination in the Stark County system of care. The first level of community treatment planning is called a Creative Community Options (CCO) meeting. The CCO process was initiated by the Cluster in 1987 to promote interagency coordination in service planning and delivery and to resolve obstacles to working with children and families. A CCO meeting may be called by the agency holding lead case management responsibility for a child and family and typically is chaired by the case manager; often a CASC mental health case manager chairs the CCO meeting. Workers are encouraged not to wait for a crisis but to call a CCO meeting any time that efforts are needed to provide creative, individualized services to help a child remain within the family or community. Direct service level staff from all involved agencies participate in the CCO process, and the family, as well as the child in most cases, are included as full participants. The stated purpose of the CCO process is to examine creatively what might work for the child and family and to develop comprehensive service strategies including an array of treatment, education, recreation, and living arrangements which are specified in a written plan. The CCO process involves reviewing the child's and family's history, strengths, and needs and then proceeding to identify options for services and supports. The outcome of the CCO meeting, which generally takes several hours, is an intensive, community-based service plan. The lead case manager is responsible for monitoring implementation of the plan; CCO groups can be reconvened to address unresolved issues or changes in a child's or family's situation.

In order to prepare families for participation in the CCO meeting, case managers take the time to acquaint them with the process and what they might expect. Role playing may even be used as a strategy to help families feel more comfortable interacting with the service providers and expressing their desires and needs.

A CCO meeting which took place during the site visit was chaired by a case manager supervisor from the CASC. The group, which included the parents and adolescent, outlined the history, prepared a "people map" showing the significant others in the child's life, and outlined strengths and problems, what works, and what doesn't work. Each of these topics was summarized on newsprint and hung on the wall around the room. The group then proceeded to brainstorm what the child needed. Among those needs identified were medication, a special education placement, respite care, crisis intervention, therapy, a structured behavioral program to earn privileges, to improve family interactions, and to

receive help for fire setting. The next phase involved identifying options to meet these needs and resulted in a package of services including home-based services, individual therapy, respite care, medication through a psychiatrist, and special education. The case manager assumed responsibility for assisting the family to arrange for implementation of the service plan.

In some cases, the CCO process is unable to resolve difficult and complex barriers to serving a child and family effectively. This may be a result of the lack of appropriate resources in the community, inability to identify funding sources for services, or the failure of planned services to meet the needs of a particular child and family. In these situations, a referral can be made to the second level of community treatment planning, the ACCORD (A Creative Community Options Review Decision). As noted, the ACCORD is a standing group comprised of mid-level managers from each of the major child-serving systems. The lead case manager for the child and family is responsible for completing a referral packet and presenting the case to the ACCORD for review. The goals of the ACCORD are to reach consensus on funding and to identify services to meet the family's needs. ACCORD members generally have the authority to commit their agency to providing services or financial support, but might have to receive approval from their respective agency executives for a highly unusual service or funding arrangement.

A case considered by the ACCORD during the site visit involved a multineed family in which the mother and three adolescents all had severe mental or emotional disturbances and extensive histories of hospitalization. One youth in particular was continuing to experience serious difficulties despite intensive home-based services, case management, home instruction, and other services. The ACCORD devised a plan that would provide a support person in the home on a full-time basis to support the mother and work with the adolescents. It was felt that an in-home aide was the only strategy not yet tried, and that this offered a chance to avert the imminent placement of one of the youngsters at Sagamore Hills. Two potential approaches for funding this service were identified, and a plan was created including the in-home aide, home-based services, case management, home tutoring, and possible placement in day treatment and vocational services. The meeting ended with responsibility assigned for pursuing arrangements for funding and hiring the in-home aide.

If a case cannot be resolved at the ACCORD level, then it can be presented to the Administrative Cluster for further deliberation and problem solving. Confidentiality requirements have not proven to be barriers at any level of community treatment planning and coordination. A common consent form was developed which allows the participating agencies to share information at the meetings with representatives of the agencies specified on the form.

Training for case managers is an issue receiving increasing prominence in Stark County. Kent State University offers a two-year associate degree program in case management at its Salem campus. The program includes internship opportunities at the CASC, and two CASC case managers have completed this program. In-service training also is provided for case managers, often involving consultants brought in to provide training on aspects of care coordination. The need for additional training for case managers across systems became evident to the Cluster, and two activities have been initiated. The first of these efforts is the development of a multisystem training program for case managers. The training program

will provide an opportunity for case managers to gain an understanding of the values and principles of case management in each system, the legal mandates of each system, and the similarities and differences among systems. It will also provide an opportunity to impart the common values and goals of the system of care to case managers system-wide. As a first step in designing the training program, a questionnaire was sent to case managers in all child-serving agencies. The survey assessed the role and duties of case managers in each system, how lead case managers are assigned, how multiple case managers work together, how the CCO process is used, and issues that should be addressed in a joint training initiative. Information gathered by the survey was used to design a training program which will provide 20 to 24 hours of training over a six to eight month period. The training program is to begin in September 1992 and will be offered to 250 persons over the course of a year in multiagency groups.

A second initiative sponsored by the Cluster is called "Walk a Mile in My Shoes" and involves the development of a rotation system for children's case managers. This project would allow case managers to rotate through the major child-serving agencies, providing them with a greater understanding of the legal mandates, philosophy, and constraints of each agency. The rationale for this project is that first-hand experience of case managers in the various child-serving agencies would enhance interagency relationships and assist in developing a more fully integrated system of care. Additionally, this rotation system has potential to pave the way for a centralized intake process for the entire system of care in the county. A grant application was submitted to the Ohio Department of Health to support planning for this case management rotation project. Despite the fact that this grant was not funded, the Cluster has proceeded with planning the project.

IX. SYSTEM OF CARE ACTIVITIES

Family Involvement

A central element of the philosophy of the Stark County system of care involves working with children in the context of their families. In accordance with this focus on families, the system has made strides in involving families in all phases of planning and delivering services. First, parents are considered to be essential participants in planning and monitoring services for their own children. This is accomplished by involving parents in the interagency processes used to develop service plans. For instance, parents play a central role in the CCO process. Some participating agencies initially expressed concern about discussing the child's and family's history and other difficult issues with parents present. However, respondents reported that the experience of parental participation in the service planning process quickly led to a recognition of the benefits of full involvement. The inclusion of parents as key participants and decision makers creates better engagement in the process and ownership of the resultant service plan. Parents are always invited to ACCORD meetings when their child's case is being considered and, in some cases, have attended Cluster meetings when their case is discussed. Children also are involved in the service planning process as appropriate, with no established age limits for such participation.

In addition to involving families in decisions about their own child, the system of care has attempted to involve parents in planning and policy making at the system level. Family members are on the CASC Board of Trustees, and the CASC Planning Committee has parent members. Parents participated in a recently completed strategic planning process for the CASC which involved reviewing and revising the agency's philosophy, mission, and objectives. When new programs are developed, such as the case management program, meetings are held with parents to obtain their input and suggestions for the design and development of the program. The Mental Health Board has members whose children have been involved in the system, although their children currently are adults.

Through the CASC, support has been provided for parents to attend statewide or national meetings related to family issues. Three parents were sent, along with several case managers, to a recent statewide meeting on case management. In addition to providing financial support for their attendance at the meeting, respite services were provided for children to enable the parents to leave home.

A significant gap in Stark County is the lack of parent support or advocacy groups focusing on children with emotional disturbances. A parent group reportedly met for a brief period of time but was unable to sustain over time due to a struggle to determine its focus. Respondents acknowledged the need for parent support groups and have identified two potential opportunities to facilitate the development of such groups. One of the three Alliance for the Mentally Ill (AMI) groups in Stark County appears interested in starting a subgroup of parents of children and adolescents. In addition, a core group of parents of youngsters in the Day Treatment Program meet regularly and participate extensively in school-related activities. Both of these possibilities present opportunities for stimulating the development of parent groups.

One positive development is a grant received by the Canton City Schools for a parent mentoring program. The project allows parents of children with disabilities to work with other parents to provide them advocacy, support, and assistance in accessing resources and to increase their involvement in their child's school.

Cultural Competence

The population in the City of Canton is 13 percent African American, and the CASC client population is nearly 20 percent African American. In order to enhance the cultural competence of the agency and its services, the CASC has implemented a number of strategies. One such strategy has involved attempting to increase the number of minority staff members at the CASC. Since Stark County is not in or near a major urban area, nor is it near a major university, it has been difficult to recruit qualified minority professionals to work at the agency. Nevertheless, the CASC has had some success in recruiting minority staff in recent years. When the Case Management Program was initiated, the agency devoted significant effort to hiring a racially balanced staff to enhance responsiveness to the needs of the children and families to be served. Staff training for this and other CASC programs includes topics related to cultural competence.

In addition to staff recruitment, the CASC has reached out to the minority community by locating services in areas that are easily accessible. For example, the agency opened an office

at the Canton Urban League located in the southeast part of Canton and saw clients at this location for several years; an outreach office currently is located at the site of an alternative school which also is in the minority community. The Shipley Center, which houses the Day Treatment program, is located in a downtown area where there is a heavy concentration of African Americans. The CASC is in the process of renovating the Shipley Center and relocating additional services to this facility.

Another step taken by the CASC to enhance cultural competence was the establishment of a task force comprised of interested staff. The group meets monthly and sponsors events to increase cultural awareness. Examples of activities organized by the task force include a luncheon with ethnic dishes and a program on Martin Luther King Day. The commitment of the CASC to increasing cultural competence was also demonstrated by the agency's devoting its 1991 annual retreat to the this topic.

In addition to the steps taken by the CASC, the Mental Health Board has also initiated activities designed to increase cultural sensitivity and responsiveness. The Board has sponsored a forum for inner city principals to discuss their concerns and the needs of their students and has sponsored training opportunities on cultural competence for mental health staff in the county. Recently, the Mental Health Board hired a consultant to assist in a planning process to meet the needs of a very small population of Native Americans who reside in Stark County. This group of Native Americans is isolated and disenfranchised and has significant service needs. The consultant was enlisted to help the Board to determine how best to reach this group as well as to find potential resources for service provision.

Transition

Services for youth in transition is an area in need of improvement in the system of care. Currently, transition plans and services for youngsters with emotional problems are handled on an individual case basis. Vocational programs are available through two vocational schools in the county, and Goodwill accepts some adolescents in its supported work program. There is some focus on independent living skills in the Day Treatment Program, but little systematic training in independent living skills.

The system has begun to address the needs in this area through some preliminary planning activities. The Children's Coordinator for the Mental Health Board has met with the adult mental health centers to discuss system issues related to transition as well as specific cases of seriously emotionally disturbed adolescents who were turning 18. Based upon the availability of a small amount of funds from the Ohio Bureau of Vocational Rehabilitation and Department of Mental Health, the Children's Coordinator prepared a proposal to use these funds to address transition issues. These funds were obtained and used to fund job coaches and other employment services for Cluster youngsters. Some consideration has been given to the idea of a case manager whose role would be to work with youth in transition. This is more of a possibility if the case management program expands.

High Risk Populations

Until recently, a collaborative effort between the CASC and Canton City Health Department focused on youngsters at risk for HIV infection and AIDS. The Health Department

contracted with the CASC to provide youths with consultation and emergency support relative to HIV testing. Short-term crisis counseling was provided to adolescents to manage the stress of being tested for HIV infection. Risk management group counseling was provided as follow-up for youngsters testing negative; for those testing positive, the CASC offered group therapy. The funding for these services was discontinued due to the lack of sufficient demand. Support groups for persons with AIDS, which could include adolescents, remain available at the Crisis Center. In addition, the Mental Health Board is represented on a task force sponsored by the Canton City Health Department which assists in planning and overseeing the community's response to the AIDS epidemic.

There are no runaway shelters in Stark County and, until recently, little direct focus on homeless children or adolescents. However, in 1992, a \$91,000 grant was received from the Ohio Department of Mental Health to serve emotionally disturbed children and adolescents who are homeless and their families. Funds can be used to provide housing for these families for up to one year.

Advocacy

While there appear to be lots of effective advocacy efforts in Stark County, there are few advocacy activities specifically on behalf of troubled children and adolescents. There are three active Alliance for the Mentally Ill (AMI) groups in the county: Advocates for the Mentally Ill of Alliance, Alliance for the Mentally Ill of Massillon, and Reason for Hope of Canton. These groups are comprised primarily of family members who have a relative with mental illness as well as some mental health consumers, professionals, and other interested parties. The groups have regularly scheduled meetings which allow participants to exchange information and experiences and to provide mutual support. In addition, they are influential advocates for needed mental health services and supports.

These AMI groups traditionally have focused on the needs of adults with mental illness, but are beginning to expand their perspective to include children. There may be potential for these groups to reach out to the parents of youngsters with emotional disturbances and to advocate for this group. The need for more organized and effective advocacy for children is recognized. In particular, respondents noted the need for parents to become more organized as consumer advocates and to identify with a national organization or movement.

One noteworthy advocacy effort for children was the Northeast Coalition for Children's Mental Health. This coalition was comprised of representatives or agencies, community organizations, citizens groups, and business groups from three counties -- Summit, Cuyahoga, and Stark. The Mental Health Board and the CASC were leaders in the coalition which focused on crisis situations such as the possible closure of a hospital which was considered an important part of the continuum of services for children in the area. Unfortunately, the coalition has not been active during the past year.

Respondents also characterized the Cluster, Mental Health Board, and the CASC as advocates for children. The CASC, for example, has sponsored meetings with legislators to focus on children's issues. Despite the advocacy activities of these agencies, it is clear that enhanced advocacy in the area of children's mental health is needed.

X. FINANCING

The primary strategies used for financing the Stark County system of care involve funding of services through the mental health system, interagency funding of services for individual children, interagency funding of service components, and maximizing all potential funding sources for services. The Stark County Mental Health Board provides a substantial amount of funds to support services for children with emotional disturbances and their families. Approximately 25 percent of the Board's budget (or well over \$2 million) goes to support children's programs at the CASC, the Crisis Center, and residential treatment centers. The funds flowing through the Mental Health Board to the service system include state general revenue, block grant funds, and a local community mental health board levy. Even though it was reported that the Stark County Mental Health Board devotes a larger portion of its budget to children's services than most Ohio mental health boards, there has been concerted effort to incrementally increase the proportion of funds spent on children and adolescents.

Interagency funding of services for individual youngsters is handled through the Cluster. The Cluster considers cases of youngsters and their families with multiple and particularly challenging needs. At the time of the site visit, the funding of the service plan for each child and family was handled on an individual case basis. The process typically involved maximizing all potential funding sources for services and then relying on participating agencies to contribute either particular services or funds to purchase needed services depending upon the circumstances of the case. Contributions of funds from the various agencies typically has been applied to the support of residential placements. To implement individualized service plans which do not involve residential placements, agencies typically have contributed and assumed the cost of services. In one case, for example, a follow-along person in the schools was provided by the education system, DHS provided a foster placement, inpatient backup was provided by Timken Mercy Hospital, crisis services by the Crisis Center, and mental health services by the CASC.

Rather than negotiating agency contributions for each individual case, the Cluster agencies felt that it would be preferable to devise a formula which would govern the participation of each agency in the funding of services for youngsters considered by the Cluster. In order to begin considering this prospect, a retreat held in January 1991 was devoted exclusively to the issue of financing. An early item on the retreat agenda involved reviewing data showing how much money had actually been contributed by each agency to support services for Cluster children in 1990. The major task of the retreat was to review a series of options for "giving your fair share to the Cluster." Four major options for funding individual service plans for youngsters were considered, and, by the end of the retreat, consensus was reached on an approach for shared funding. The basic approach adopted at the retreat called for each agency to agree to a standard formula to be used to fund services. This standard percentage of participation would be used for any case funded by the Cluster. The monies to be contributed would remain in each agency's budget, but would be money committed in advance to the Cluster up to a predetermined ceiling amount. At the conclusion of the retreat, each agency agreed to seek approval from its board for the recommended percentages of participation. It also was decided to seek advice from the state auditor as to the legality of or any potential problems related to an agency's setting aside categorical funds to fund individual service plans developed by the Cluster. The primary concern prompting this

consultation was that an agency might find itself in the position of spending its funds to support services for a child who might not be eligible for its services.

The agreement reached during this retreat culminated in the signing of an interagency contract in January 1992. The signing of the contract was considered a momentous event in the evolution of the Stark County system of care since it formalized the shared responsibility of the participating agencies in terms of service provision and financing of services for children. A number of state and local officials were present for the signing of the agreement, and extensive press coverage marked the significance of the event for the community. The agreement specifies that the core agencies involved in the Cluster will set aside a total of \$350,000 for the purpose of funding the service needs of appropriately determined children presented to the Cluster during the first six months of 1992. The percentages of this amount to be contributed by the various agencies are:

o	Stark County Department of Human Services	49%
o	Stark County Mental Health Board	30%
o	Stark County MR/DD Board	20%
o	Alcohol and Drug Abuse Services Board	1%

The agreement further specified that each core agency would pay a proportionate share of the entire cost of services provided to each multineed child based upon the above percentages, with funding of services for a particular child and family to be determined by a vote of the representatives of the core agencies. Three votes in favor of funding a child were required in order to bind the core agencies to these financial obligations. Other member agencies participating in the Cluster could consider contributing resources to support services on an individual case basis. Thus, the school districts, health departments, Family Court, CASC, and Job Training Partnership might assist in funding services in appropriate cases. This would result in proportionate reductions of the contributions of the four core agencies. The agreement stated that the lead case manager identified for the child in question would be responsible for pursuing all other appropriate sources of funds including parental support, insurance, Medicaid, Social Security, and Supplemental Security Income. Any costs of services recovered from these sources were to be reimbursed to all contributing agencies in proportion to their contributions.

With the expiration of this agreement in June 1992, a new agreement has been developed which will become effective on July 1, 1992. Based upon the first six month's experience, the new agreement changes the procedure for blending funds and financing services in order to streamline and simplify the process. Under the new agreement, DHS is designated as the fiscal agent for the Cluster, and all participating agencies advance their funds to the DHS. DHS then pays all bills for services provided to Cluster children from the blended pool of funds. This new process eliminates the complicated process of each agency paying for each individual youngster based on the preestablished percentages. Any funds recovered from other reimbursement sources revert directly to the Cluster blended fund. Under the new agreement, additional agencies are contributing to the blended funding pool. In addition, a process has been established to cover administrative costs of the Cluster; the Cluster Coordinator submits monthly bills for expenses including costs of retreats, telephone, postage, and clerical support, and DHS pays these expenses out of the blended funds.

Joint funding of service components or programs is another strategy used successfully to finance services in Stark County. The Day Treatment Program, Child and Family Advocacy Center, TIES Program, Youth Sex Offender Program, and School-Based Mental Health Services are examples of programs that have been jointly operated and funded by two or more agencies. Respondents acknowledged that the community has been more successful at blending funds from multiple agencies on an individual case basis than on a programmatic level. A future goal of the Cluster is to increase opportunities for blended funding to create and operate additional services or programs for children and adolescents.

As noted, attempts are being made in Stark County to maximize the use of all available funding streams to support services. This is being encouraged on an individual case level, with the case manager being responsible for pursuing all potential revenues. Similarly, attempts are underway at the system level to expand utilization of all possible financing sources. Medicaid, in particular, is a source of support for services which has been underutilized in the county. Mechanisms for expanding Medicaid reimbursements are being explored vigorously by the Cluster, specifically focusing on EPSDT as a vehicle for expanding both eligibility and the range of reimbursable services and utilizing the 1915A option. This option would allow identification of "Cluster children" as a target population as well as reimbursement for new services.

Regarding problems related to financing, respondents indicated that, like most communities, there simply is not enough money to provide all the needed services and supports. The lack of sufficient funds is a problem that continues to plague the system and is not likely to improve given the current fiscal crisis in Ohio. Rather, budget shortfalls at the state and local levels are forcing cuts in all human services, including services for children and families.

XI. EVALUATION

Participants in the Stark County system of care recognize the importance of evaluating system outcomes and have initiated some evaluation activities. In 1989, the CASC hired a consultant to propose methods for evaluating Cluster activities. The report generated by the consultant discussed issues related to evaluation methods, designs, and potential indicators for evaluating Cluster activities and outcomes for children and families served by the Cluster. A number of options for evaluation at the Cluster and client levels were presented in the report as well as recommendations such as the creation of a database on children and families served by the Cluster. Cluster retreats also have generated ideas for evaluating the effectiveness of the evolving system of care.

While these planning activities related to evaluation have occurred, progress in evaluating the system of care has been slow. The index used most frequently to demonstrate progress in Stark County is the dramatic reduction in out-of-county psychiatric placements that has been achieved. As noted, there were 141 youngsters in out-of-county placements in 1976. The number of youngsters in out-of-county placements fell to 55 by 1985, a reduction which is attributed to the development of a broader array of community-based services coupled with an explicit commitment by the child-serving agencies to serve children in the community. By 1991, out-of-county placements were reduced to only 15, representing a decline of nearly

90 percent from the 1976 rate. A similarly striking decline in the utilization of the state hospital for Stark County youngsters also has been achieved. In fact, the average bed days utilized at Sagamore Hills fell from seven in 1989 to 1.5 in 1992.

In order to track out-of-county placements more systematically, a multiagency monthly reporting system has been developed. This monthly report is submitted to the Cluster by each of the major child-serving agencies and specifies the number of youngsters in each type of out-of-home placement within the county and out of the county. The reporting form covers the range of potential out-of-home placements including inpatient psychiatric, inpatient substance abuse, residential treatment, group home, shelter care, therapeutic foster care, regular foster care, and detention settings. The reporting system is expected to result in accurate and timely information about the utilization of out-of-home placements by all the child-serving agencies and will be useful in system assessment and planning activities.

The use of out-of-county placements as an indicator of effectiveness for the system of care is consistent with the goals and values of the system. In fact, there appears to be considerable agreement as to some of the measures that should be used to assess the effectiveness of the system of care. These include:

- o Reduction in out-of-county placements,
- o Reduction in out-of-home placements,
- o Reduction in rate of hospitalization, and
- o Improved quality of services.

Another focus of evaluation efforts at the system level has involved evaluating the CCO process. A questionnaire assessing the CCO process was developed and administered to participants of CCO meetings that were held over a 12-month period of time; 36 surveys were returned. The questionnaire asked for perceptions of the purpose of the meeting and for feedback about each of the major sections of the CCO meeting. Questionnaire respondents also were asked to state if the plan developed for the child and family was satisfactory and if the CCO process was of value and to make recommendations for its improvement. The vast majority of respondents thought that the plans developed were acceptable and judged the process to be of value. Interestingly, parents gave the most positive feedback, making comments like: "Thank you for inviting me," "Nobody asked us before," and "I can't believe that this many people wanted to help us." Some professionals, however, indicated discomfort with having the parents there. Regarding suggestions for improvement, reducing or limiting the amount of time the CCO meetings take was the most frequent recommendation. In response, case managers have been asked to prepare the history section ahead of time and to do additional advance preparation in order to save time at CCO meetings.

Another activity under consideration in Stark County is the development of a multiagency management information system. This tracking system would provide a mechanism for sharing information on active, multiagency youngsters in a more reliable and systematic fashion. Several agencies went as far as to submit a joint grant application for a shared data system, but the grant was not funded. The Cluster submitted a proposal to the State Level Cluster and Governor's office asking to be established as a pilot county to test the feasibility of a multiagency data system. While the Cluster has not established this as a current priority, there remains interest in pursuing this possibility in the future.

In addition to these system-wide evaluation activities, there have been some evaluation activities related to individual service components. These activities are undertaken annually by the CASC, with the results summarized in the CASC's annual quality assurance report. The process used by the CASC involves monitoring one or two key indicators for each program. Further evaluation is undertaken if the monitoring activity suggests some problem with the quality or outcome of care. The conclusions are then used to change or improve the program in some way and to improve the monitoring process.

For the Intensive Home-Based Services program, the monitoring activity focuses on maintenance of children in the least restrictive, most normative environment. The indicator used to assess this aspect of care is removal from the living situation to a more restrictive, less normative setting such as a hospital, detention center, or foster home. A threshold was established specifying that no more than 15 percent of clients served should be placed in a more restrictive or less normal environment. The 1990 report indicates that the program exceeded this threshold with a removal rate of 33 percent. This result triggered further evaluation and efforts to determine why the placement rate during 1989 was higher than predicted. The report explains this result by noting that the program has a reunification focus and serves youngsters returning from Sagamore Hills and other inpatient psychiatric settings. A literature review and survey of several similar programs found that similar family reunification programs serving similar populations tend to have lower "success" rates than programs with a primary placement-prevention focus. Thus, the threshold might have been inappropriate. Additionally, these data reflected the first year of the program's operation during which many operational problems were encountered. The follow-up plan included reviewing the monitoring activity and possibly changing the threshold as well as continuing to gather data related to successful family reunification. Additional measures, such as client/family functioning scales, may be considered in order to assess more fully the effectiveness of the program. The threshold for 1991 was, in fact, raised to 40 percent. The 1991 report indicated that only 13 percent of the youngsters served by the Intensive Home-Based Services program were placed in more restrictive settings during that year, a finding well within the established goal and threshold.

For Day Treatment the indicators used for monitoring purposes include frequency of utilizing seclusion, temporary or longer-term admissions to more restrictive placements, and placement in a more restrictive environment upon discharge from Day Treatment. For all programs and services of the CASC, several indicators are used to gauge effectiveness -- bed day utilization at Sagamore Hills, hospitalizations, suicide attempts, and client satisfaction. Thus, without a major commitment of resources, the CASC has implemented a monitoring system which relies upon key measures and which signals the need for further evaluation. It is important to note that the information gathered through this monitoring process clearly is used as a basis for resolving problems and improving care.

A somewhat more elaborate system for tracking client outcomes has been recently created for the Case Management Program. For each youngster receiving case management services, the CASC monitors:

- o Entitlement Programs - Whether appropriate entitlement programs have been received
- o Stable Housing - Whether the child has had stable housing (living with the same family or treatment setting) in the community for one year or more
- o Community Tenure - Whether the child has had no psychiatric hospitalizations for one year or more
- o School Tenure - Whether the child has remained in school for one year or more
- o Restrictiveness of Setting - Whether the child has moved into a more or less restrictive setting in school or housing areas
- o 508K Submission - Whether the 508K was submitted in the current fiscal year

Another new development in the area of evaluation is a case review process whereby the status of each youngster and family served by the Cluster will be assessed on a regular basis. The review process involves an interview with the child and with the providers to determine progress, the appropriateness and responsiveness of services, and problems that should be addressed at the Cluster level. Members of the ACCORD are responsible for conducting the case review procedure.

XII. MAJOR STRENGTHS AND CHALLENGES

Through interviews with key informants representing a wide variety of constituencies involved in the Stark County system of care, a number of factors that are critical to the success of the system were identified. The major strengths of the Stark County system include the following:

- o **Leadership** - One of the principal strengths of the Stark County system lies in its leadership. The involvement and commitment of the executives of the child-serving agencies in the community have provided the impetus and continuing support for system of care development over time. The Cluster has provided a forum for agency executives to remain closely involved in decision making about both system development and individual youngsters. Respondents emphasized that the close direct participation of agency executives in planning and overseeing the system of care has been essential for sustained progress. Thus, the leadership provided by a core group of agency executives, coupled with their long-standing commitment to system of care development, has been crucial to the success of system development efforts in Stark County.

Respondents noted that the stability of the key players in the Stark County system of care may also contribute to its success. Many of the leaders have served in the Stark County system for many years; they may have served in different capacities and been involved in different aspects of planning and decision making for the system. This "tapestry" of players or recycling of individuals on various task forces, committees, and the like has created a sense of continuity and history in the community. The personal relationships that have developed among these key leaders in the system also have proven to be an asset. Respondents described a group of

people who get along well, who interact effectively, and who have developed high levels of trust based upon long-standing working and personal relationships.

- o **Shared Responsibility and Vision** - A strength that became apparent during the site visit is the sense of shared responsibility and mission that pervades the Stark County system of care. Respondents from the various agencies expressed a sense of collective ownership of the target population, indicating that participants have succeeded in bridging some turf barriers and in embracing the belief that children and families have multiple needs which cannot be met by individual agencies in isolation. Participants appear to regard the Cluster as "greater than the sum of its parts" and genuinely believe that they will be more effective if they accept joint responsibility for Stark County children and families and work together to build a comprehensive service system.

Similarly, the philosophy of the system of care in the county appears to be well-ingrained and shared among the various participating agencies. The basic elements of the system philosophy began to be articulated nearly 20 years ago, resulting in a widely accepted vision and goals for the system of care. The concepts of interagency collaboration, serving children within the home and community, and family focus appear to be accepted both by agency executives as well as most providers. This shared responsibility for multineed youngsters and their families and the shared vision and goals for a system of care have provided a firm base for system development.

- o **Proactive Attitude** - Respondents emphasized that Stark County has not received a great deal of special or extra funding to support their system development efforts. Nevertheless, the sheer determination to create an effective system of care has enabled the community to proceed without many extra grants or support. The community has been described as "the little engine that could," moving ahead and taking action with few resources and in the face of formidable barriers. Much of the progress in Stark County is attributed to a proactive attitude which moves the system ahead in spite of scarce resources or disappointments such as unsuccessful grant applications. Participants expressed the attitude of doing "whatever it takes" or "just doing it" rather than waiting for grants or other opportunities. The Cluster tends to focus on what is possible rather than on constraints or what is not possible. Thus, an important strength in Stark County is a proactive and positive attitude which emphasizes what can be accomplished and propels the community to take action to address identified problems.
- o **Cooperative Approach to Problem Solving** - A cooperative approach among the participating agencies was identified as an important strength in Stark County. As noted, the belief that the various child-serving agencies will be more effective collectively and the joint sense of responsibility for troubled children are evident in the community's efforts. Beyond this, however, is a willingness to confront and resolve problems openly and in good faith. When the inevitable disagreements among agencies arise, participants do not leave the table, but rather are committed to working them out. Further, participants appear committed to working with "reluctant" agencies over time, providing encouragement meaningful opportunities for

them to become more involved. Often the retreat process has successfully been used as a forum for discussing and resolving disagreements among system participants.

- o **Service Implementation** - The creation and gradual expansion of an array of services within the community is a major strength of the system of care. The CASC established the goal of developing a comprehensive continuum of care early in its history, and over time has built the capacity to provide services including day treatment, intensive home-based services, emergency in-home services, services for sex offenders, case management, and individualized wraparound services. The ability to translate plans into actual service capacity is an essential aspect of system building and is an aspect in which Stark County has realized particular success.
- o **Size of Community** - Several respondents postulated that the size of the community may be an asset that has facilitated the community's system building efforts. The community is not so small that it is bereft of services and resources, nor is it so large as to be unmanageable. Rather, Stark County is a moderately sized community which has a respectable array of services and resources and in which human service personnel tend to know one another. Respondents speculated that larger metropolitan areas may face additional challenges in creating multiagency systems of care. The multiplicity of agencies and personnel may result in disorganization and fragmentation. From an organizational standpoint, it may be necessary to break larger metropolitan areas down into more manageable service areas in order to maximize the probability of developing a cohesive, coordinated system of care with effective services and interagency relationships. Thus, the size of Stark County may be a factor that has facilitated system development.

While the Stark County system embodies a number of noteworthy strengths, it also faces a number of challenges which must be overcome in order to ensure continued development of the system of care. These include:

- o **Funding** - Most communities report that financing presents the most significant barrier to system of care development. In Stark County, respondents related that, in fact, the lack of adequate funding presents a formidable challenge to the child-serving agencies in their attempt to create a comprehensive community-based system of care. Insufficient funding to create the needed service capacities has slowed progress as have the constraints presented by inflexible, categorical funding streams. Respondents indicated that financing streams have not yet caught up with the changes in philosophy and approach used in state-of-the art community-based systems of care. While the Cluster has used creative approaches to blend funds and fund individualized service plans for children and families, additional funding opportunities and creative solutions will be needed to continue system development. The current fiscal crisis in the State of Ohio may only serve to compound the challenge of locating and creating financing sources for the system of care.
- o **Human Resource Needs** - The need for qualified personnel to provide services within the system of care represents another critical challenge for Stark County. Agencies have found it difficult to recruit specialists in children's mental health services, particularly those who are adequately trained, and prepared, to work in

nontraditional programs such as home-based services and case management. This is due partially to the limited pool of mental health professionals specializing in children's services as well as to the inadequate training currently provided by most colleges and professional schools.

The community has taken some steps to address human resource needs for the system of care. The Children's Coordinator of the Mental Health Board approached a faculty member in the Center for Family Studies at the University of Akron to discuss the need for trained professional to provide home-based services. Their discussions resulted in the preparation of a grant application for the development of a training program in this area. The grant ultimately was funded by the Ohio Department of Mental Health, and an interdisciplinary training program was developed which provides graduate level training for home-based therapists. Another step taken to address human resource requirements was the design and implementation of a psychology internship program at the CASC. The internship program, which is approved by the American Psychological Association, provides a diverse set of experiences to interns, enabling them to develop expertise in community-based service approaches. The interns augment the staff in the various CASC programs, and some are expected to remain working in the system of care in some capacity following completion of their education. Despite these activities, the need for adequate numbers of trained staff remains a challenge for the Stark County system as well as for other communities seeking to develop systems of care.

o **Educating Line Staff** - The system of care philosophy, though clearly articulated and accepted at higher levels, does not always "trickle down" to line workers. Thus, a continual challenge for the community is to ensure that line workers in all child-serving agencies are well-versed in, and accept, the system of care philosophy and values including the collaborative interagency relationships and approach. Staff turnover at all agencies compels the process of educating line staff to be ongoing and also compels managers to continually model and reinforce the philosophy and collaborative attitudes. Managers emphasize that a system cannot function when a philosophy is accepted only at administrative levels and there is merely hope that it will filter down. Rather, conscious attempts must be made to sell the ideas at all levels of the system until they become ingrained in the system.

A difficult challenge has been to change the attitudes and approaches of staff trained in more traditional service delivery approaches. For example, outpatient services at the CASC have used an office-based approach, typically relying on weekly 50-minute counseling sessions. In many communities, resistance is encountered when an attempt is made to shift to more intensive and flexible approaches. Educational strategies, coupled with first-hand experience with new approaches, are needed in Stark County for continued change in both attitudes and priorities as the system of care develops.

o **Service Gaps** - Filling service gaps represents yet another challenge for the Stark County system of care. While there has been remarkable progress in developing a service array in the community, respondents agreed that several types of services are sorely needed -- therapeutic foster care, crisis residential services, and services for sex

offenders. The Cluster is addressing each of these gaps and attempting to develop both strategies and resources to support the development of these services.

A related, and perhaps more arduous, challenge is to increase the capacity of existing services to more adequately meet the need in Stark County. As noted, wait lists are common at the CASC, and nearly all programs do not have the resources to serve all youngsters who are eligible and in need of services. This has proven to be troubling and frustrating for the participating agencies seeking services for youngsters as well as for the CASC managers and staff. Impending cuts in funding for mental health and other human service funding may further exacerbate this situation, and, given the current economic climate, there is little hope for major expansion in either funding or service capacity. Thus, as the system evolves attention will be needed both to create missing service components as well as to increase the capacity of existing services.

One strategy being implemented to partially address this problem involves offering a brief consultation service during intake. If a family situation appears to be deteriorating, intake staff can provide one to two sessions of face-to-face consultation either in the office or home. The purposes of such consultation include identifying community resources that can be accessed quickly and providing some crisis intervention and support. The consultation is seen as a problem-focused, directive, short-term intervention to offer some specific resources and suggestions to the family and to assist in appropriately prioritizing children and families for the CASC waiting list. No fees are charged to either clients or third parties for this consultation service.

- o **Family Support and Advocacy Groups** - Stark County has succeeded in involving parents in the system of care in many ways. Parents are involved in planning and monitoring services for their own children, and parents are participants in planning and policy making at the system level through a variety of advisory entities and activities. A significant gap, however, is the lack of parent support and advocacy groups in the county which focus on children with emotional disturbances. The need for increased opportunities for mutual support among parents as well as the need for parent advocacy is acknowledged. However, little progress has been achieved in this area to date. An important challenge for the future development of the Stark County system is to stimulate and facilitate the development of parent groups which may ultimately fulfill the functions of both parent support and parent advocacy.
- o **Involvement of All Agencies** - In creating a coordinated system of care, most communities encounter one or more agencies which are reluctant to participate fully in interagency entities and activities. Care must be taken to ensure that those agencies which appear less committed to the collaborative efforts do not impede progress. In Stark County, as elsewhere, continual efforts are required to involve all child-serving agencies, even those which may be less enthusiastic participants.

One challenge in Stark County is presented by the fact that local school districts have not been closely involved in the Cluster. The Special Education Director of the Canton City Schools has been an active and dedicated Cluster participant and has served as a liaison with the other 16 local school districts in the county. While this approach has been effective, the lack of involvement of the local districts may

aggravate some of the relationship problems with the education system. For example, staff noted that it often is difficult to arrange for appropriate educational placements for youngsters with emotional problems and that some local districts resist testing children and paying for special education and supportive services. The more peripheral involvement of these districts provides fewer opportunities to explore and resolve such intersystem issues. While it may not be feasible to have each local district involved in the Cluster, there may be more systematic and creative opportunities to induce closer working relationships with all of the local education agencies.

- o **Community Education** - Another challenge for the system of care is to better educate the community about the needs of troubled children and their families and about the work of the Cluster. Respondents indicated that while Stark County is recognized for its progress in creating a system of care, the community knows little about either the progress achieved or the work that remains to be done. Public awareness and education are needed to create a broad base of support for the system of care as well as to generate future financial support for services. Local tax levies remain an important source of financing for several of the child-serving systems, and, therefore, the future of Stark County's system of care may rest squarely in the hands of its citizens.

While these complex challenges remain, Stark County has made substantial and impressive progress toward creating a community-based system of care which includes a broad array of services and mechanisms for interagency coordination at both the system and client levels. Respondents noted that their progress was considerably enhanced through periodic retreats for all participating agencies with an outside facilitator. The retreats have provided agency executives an opportunity to escape from their demanding schedules and from the inevitable daily crises which consume their attention and energy. Retreats have offered blocks of time for planning, problem solving, and reaching agreement on key aspects of the system of care including its vision and goals, operating procedures, and financing strategies. The use of a skilled facilitator has assisted the group in remaining focused on the critical issues and on developing and following through with agreed-upon action steps. Stark County participants asserted that the use of retreats and a facilitator could be highly significant and effective tools in the developmental process of a system of care in any community.

❖ Stark County Interagency Children's Cluster

Vision Statement

We visualize:

"A unified system that energizes all services around each child's needs so they can realize their maximum potential. This system provides positive alternatives within the community so that the child will have the opportunity to build on his/her strengths. This system effectively supports positive family functioning and nurtures children in a socially, emotionally and educationally sound environment which persists into adult life."

The Driving Principles for the System of Our Vision

- ❖ Identify and accept without exception all those who are in need through a proper and appropriate assessment.
- ❖ Child centered and individualized service with a family focus.
- ❖ Develop an aggressive program that wraps services around the child's/family's needs and provides whatever services are needed. (Whatever it takes!)
- ❖ The community is part of the solution and not the problem.
- ❖ Everyone has the right to life, liberty and happiness.
- ❖ Parents of the youth are involved as partners in the definition of the issues as well as the solutions.
- ❖ Have the least restrictive, community-based services.
- ❖ Have community awareness of various systems that provide services to children.
- ❖ The focus is on prevention and the child's and family's strengths, rather than pathology.
- ❖ Everyone has self-worth, and change can occur.
- ❖ The system of care will accept every child no matter what his or her disability with a "no eject, no reject" from the services philosophy.

The agencies and resources represented by the undersigned are committed to the realization of this vision:

Joseph F. James, Ph.D., Superintendent, Chairman
Stark County Board of Mental Retardation and
Developmental Disabilities

A. Leslie Abel, Executive Director
Stark County Community Mental Health Board

Michael Johnson, Executive Director
Child and Adolescent Service Center

John McCall, Program Administrator
Department of Human Services

Robert E. Pattison, Health Commissioner
Canton City Health Department

Francis Pratt, Director of Social Services
Stark County Board of Mental Retardation and
Developmental Disabilities

M. Louise Spence, Director
Lincoln Way SERRC

Ronald West, Director of Special Education
Stark County Local School System

Richard DeHeer, Director of Court Services
Stark County Family Court

The Honorable Julie Edwards, Judge
Stark County Family Court

Patricia A. Miller, Stark County Commissioner

Cleo Lucas, Coordinator
Major City Flow-Through Funds
Canton City Schools

Creating a Neighborhood of Services

SERVICES TO THE CHILDREN (WHAT THE CLUSTER DOES NOW)

Direct Services:

- Early intervention
- Case coordination
- Community options plan
- Individualized service plan
- Coordinated assessment
- Advocacy
- Coordinated monitoring

Cluster Purchases Services:

- Therapeutic foster homes
- Residential treatment centers
- Foster care
- Home-based care
- Respite
- Day treatment
- Tutors
- F.R.S. respite care
- "Friends" for kids
- Hired classroom aides
- Day camps for kids
- Child and Adolescent Service Center

Outcomes of Cluster:

- Keeping children with families
- Keeping kids in Stark County
- Save money
- Effectively spending the same money
- Keeping kids with their families
- Model for others
- Cutting edge
- Prevents kids from falling through the cracks
- Reduce long-term problems
- Increase daily living skills
- Have a comprehensive system of services
- Prevented kids from being in residential care
- 14 kids in residential care in Stark and these kids need it
- We can challenge any county with our statistics
- We are saving money now
- 85% of kids in day treatment have remained in-home
- Many day treatment kids stay in less restrictive placements

STARK COUNTY INTERAGENCY CHILDREN'S CLUSTER

A.C.C.O.R.D.

A C_{REATIVE} C_{OMMUNITY} O_PTION_S R_{EVIEW} D_{ECISION}

INCLUDING PROTOCOLS
FOR
C_{REATIVE} C_{OMMUNITY} O_PTION_S

CCO MAY INCLUDE

Child and Family
Lead Case Manager
Teachers
Mental Health Therapists
Drug/Alcohol
Juvenile Court
Group Home Staff
Hospital Staff

ACCORD

Lead Case Manager
Beth Dague
Bonnie Pitzer
Thelma Coss
Karen Wilder
David Wells
Sue Kunkle

CREATIVE COMMUNITY OPTIONS

Creative Community Options (CCO) meetings are community treatment planning meetings which may be called by any agency/system which is involved in the Children's Cluster. These meetings are usually called by the system who currently holds the lead case management responsibility and always involves the child and family in the planning process. The systems which may convene a CCO meeting are:

- Alcohol and Drug Addiction Services Board
- Child and Adolescent Service Center
- Department of Human Services
- Family Court
- Mental Health Board
- Mental Retardation/Developmental Disabilities
- Schools

The purpose of these CCO meetings are to creatively examine what might work for the child and family in developing treatment strategies which cover the range of needed services including where the child lives and what direction all of the involved systems are headed. CCO meetings are not used to discuss the issue of money, of who or what system will pay, any issues of blame for parents or blame between systems. It is strongly felt that such negative discussions prevent creative solutions to problems. The purpose of the CCO meeting is to develop an array of treatment, education, recreation, and living arrangements written into a plan which will work for the child.

STARK COUNTY INTERAGENCY CHILDREN'S CLUSTER Creative Community Options Meeting

We will try to do four things at this meeting.

First, we will briefly describe the major events that have occurred in the child's life. The purpose of this step is simply to gain a better understanding of who the child is and how their past may be related to what is happening now.

Second, we will describe what life is like right now for _____. You can help with this because you know him well.

- What is going well that we can build on?
- What is not going so well, which are barriers to progress?

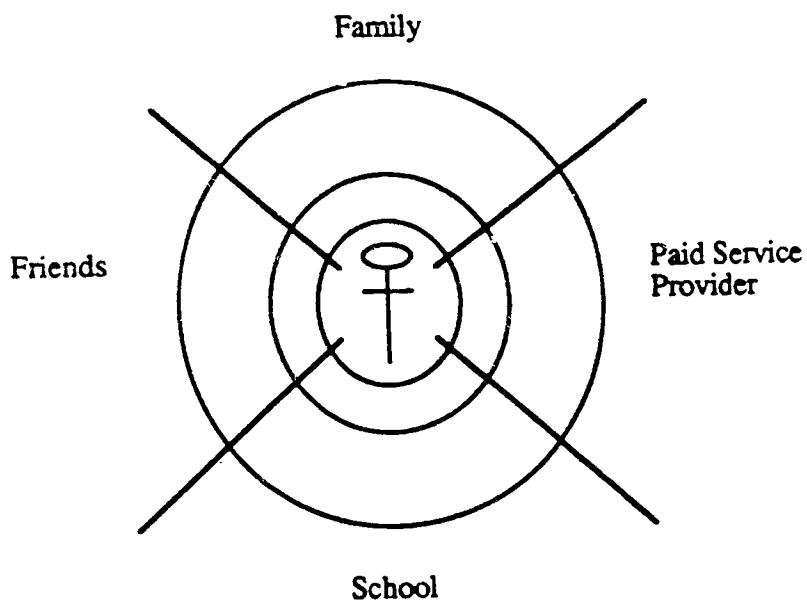
Third, we will take some time to dream a bit, so we can picture what we would like life to be for _____ at some point in the future--a better brighter future.

Finally, we will decide what various people would have to do so that _____ could achieve the future we have projected. We want to think together about what kinds of changes we all might have to make to accomplish this. We will explore existing services and also work to create new services to meet the needs of _____. By the need of the meeting, we should have a good start on developing the list of ways we, as a community, can help in planning with and for _____.

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CREATIVE COMMUNITY OPTIONS

1. Introduction of Participants
2. History/Chronology
 - Births
 - Deaths
 - Moves/Placements
 - Medical problems/Medication/Hospitalization
 - Court Involvement
 - Schools/Special programs
 - Divorces/Remarriages
 - Agency Involvements/Services (Dx/IQ)
 - Traumas
 - Important Events
3. People Map



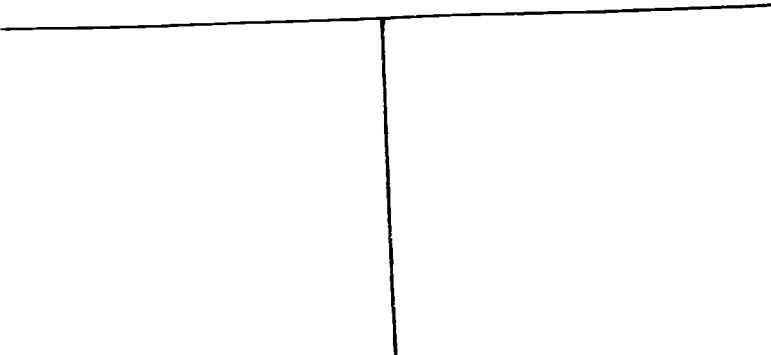
4. Strengths Problems

+

5.

What Works

What Doesn't Work



6.

What would we want?

7.

Plan: Who will do what?

CREATIVE COMMUNITY OPTIONS QUESTIONS AND ANSWERS

What is Creative Community Options (CCO)?

Community treatment planning meetings which are their strengths based assessments of children and families.

Who calls a CCO meeting?

Any case worker/case manager in any system
Alcohol and Drug Addiction Services Board
Child and Adolescent Service Center
Department of Human Services
Family Court
Mental Health Board
Mental Retardation/Developmental Disabilities
Schools

When do you call a CCO meeting?

Anytime the lead case worker/case manager would like help in creatively planning services for a child and family, in bringing together everyone who has any connection with the child so that all community resources and agencies can work together with the family. CCO's work best before the crisis happens. All case managers/case workers are encouraged to call a CCO meeting early in the case. CCO meetings are not solely to discuss placements for children. Rather they are creative attempts to wrap services around the child and family so that child may stay within their communities.

Who attends a CCO meeting?

- The child and family
- Any agency involved with the family; i.e. mental health, drug and alcohol
- Schools
- Family Court
- Department of Human Services
- Mental Retardation/Developmental Disabilities
- Foster parents
- Any previous/past provider

Who calls the CCO meeting?

Any case worker/case manager may convene a CCO meeting.

Is there a format and process to follow?

Yes

FLOW CHART
CREATIVE COMMUNITY OPTIONS PROCESS

STEP 1

CHILD AND FAMILY ENTER ANY SYSTEM

Any agency or system within the Stark County Interagency Children's Cluster contacted.

STEP 2

LEAD CASE MANAGER IDENTIFIED

Determines eligibility for services and contacts other agencies when appropriate.

In the event there is a disagreement regarding lead case manager, the case manager receiving the referral will assume the lead role until one can be identified by the ACCORD Team.

STEP 3

AVAILABILITY AND APPROPRIATENESS OF SERVICES

If services are available, the lead case manager will assist in the referral process to the agency. If services are not available, the lead case manager will call a CCO meeting.

STEP 4

CREATIVE COMMUNITY OPTIONS MEETING

Lead case manager initiates CCO procedures and contacts providers and other agencies as needed to participate in meeting.

OUTCOMES

If funding is agreed upon at the CCO meeting, the lead case manager will assist in the referral process to the agency and agreement. If no funding agreement can be reached and/or resources are not available, a referral is made to ACCORD.

STEP 5

REFERRAL TO ACCORD

Lead case manager completes ACCORD packet consisting of State Cluster referral form and contacts the mental health board office to have the child/family placed on the ACCORD agenda.

STEP 6

ACCORD TEAM MEETING

Reviews CCO recommendations

If consensus is reached, lead case manager will assist in referral process to the agency and agreement. If no consensus can be reached on services and/or resources, a referral is made to the Administrative Cluster.

STEP 7

ADMINISTRATIVE CLUSTER

Reviews ACCORD Team recommendations
If a consensus is reached at the ACCORD meeting, it is reported at the regular Cluster meeting as part of the minutes and no further action is required. If no consensus is reached, the Administrative Cluster will first try to resolve the issues locally, and, if not, a referral will be made to the State Cluster. In that case, the lead case manager will complete referral packet and forward.

STEP 8

SEMI-ANNUAL REVIEWS

ACCORD Team will conduct Cluster case reviews on a semi-annual basis and present their findings and/or recommendations to the Administrative Cluster.

STEP 9

MINUTES

Page six of the State Cluster referral form will be attached to ACCORD minutes and filed at the mental health board as part of the Cluster records.

STARK COUNTY
CREATIVE COMMUNITY OPTIONS MEETING
CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Client's name: _____
Date of birth: _____

I, _____, authorize:

- ____ Child and Adolescent Service Center
____ Stark County Board of Mental Retardation and Develop-
mental Disabilities
____ Stark County Department of Human Services
____ Stark County Community Mental Health Board
____ _____ (school district)
____ _____ (health department)
____ Stark County Family Court
____ _____ (other)
____ _____ (other)

To share information in a C.C.O. meeting with representatives
from each of the following agencies:

I also authorize that a copy of the plan only will be pro-
vided to participants so that the plan may be implemented by
designated participants.

I understand that this information will be released only to
the participating agencies and any information released to
participants will not be re-released without prior author-
ization. I further understand that these records are pro-
tected by state and/or federal confidentiality regulations
and cannot be disclosed without my written consent unless
otherwise provided for in the regulations. I also understand
that I may revoke this consent at any time. In any event,
this consent expires automatically ninety (90) days after the
date below.

Signed this _____ day of _____ 19 ____.

Signature of parent or guardian: _____
Witness : _____

Revoked _____
(Date) (Signature)

Witness: _____ 200

**STARK COUNTY CHILDREN'S CLUSTER
CREATIVE COMMUNITY OPTIONS (CCO) SERVICE MENU**

CLIENT INFORMATION

CHILD'S NAME: _____

PARENT'S NAME: _____

CUSTODIAN'S NAME: _____

DATE OF CCO MEETING: ____/____/____

DATE PRESENTED TO ACCORD: ____/____/____

PRESENTED TO THE ACCORD BY: _____

LEAD CASE MANAGEMENT SYSTEM: _____

WRAPAROUND SERVICE MENU

ENTITLEMENTS & OTHER FISCAL SOURCES

SSI	SSDI	MEDICAID	TITLE IV-E
\$ _____	\$ _____	\$ _____	\$ _____

PRIVATE INSURANCE _____

ADDRESS _____

NAME OF INSURED _____

PARENT CONTRIBUTION _____

CHILD'S SCHOOL DISTRICT _____

RECOMMENDATION	FILE
APPROVED BY ACCORD: AUTHORIZED FOR: ____ MONTHS	COPY TO: <u>MHB</u> <u>ADA</u> <u>DHS</u> <u>MR/DD</u> <u>SCHOOL</u>
REAUTHORIZATION DATE: ____/____/ REAUTHORIZED DATE(S) ____/____/____/____/____/____	OTHER: _____ OTHER: _____

... WRAPAROUND SERVICES MENU ON REVERSE SIDE ...

WRAPAROUND SERVICES MENU

Please identify what services are to be provided to the child & family by all of the systems and agencies involved in serving the child.

Identify costs, by unit of service or per diem & what costs are to be paid by the Cluster. If you do not know the cost of a service provided by your system or agency, please leave the cost blank. However, be certain to identify all of the systems participating. You must identify the cost of a service if the Cluster is expected to pay for the service.

WRAPAROUND SERVICES

<u>IN-HOME SUPPORTS (INCLUDE PARENT INCENTIVES)</u>	<u>PROVIDED BY</u>	<u>COST</u>
<u>COMMUNITY SUPPORTS (INCLUDE OUTPATIENT SERVICES)</u>	<u>PROVIDED BY</u>	<u>COST</u>
<u>SCHOOL SUPPORTS</u>	<u>PROVIDED BY</u>	<u>COST</u>
<u>THERAPEUTIC FOSTER CARE</u>	<u>PROVIDED BY</u>	<u>COST</u>
<u>RESIDENTIAL</u>	<u>PROVIDED BY</u>	<u>COST</u>
<u>SECURE RESIDENTIAL</u>	<u>PROVIDED BY</u>	<u>COST</u>

CLUSTER CHILD PROFILE

INSTRUCTIONS

Items 1 thru 8 must be filled out completely. If they are not, the form will be returned. For those items in Boldface Type, please refer to the attached Coding Guide for the proper code(s) to be entered beside the description of the item you are completing.

..ALL ITEMS IN THIS BOX MUST BE FILLED IN OR THE FORM WILL BE RETURNED..

1. Last Name _____	2. First Name _____		
3. Birthdate ____/____/____	4. Gender ____	5. Race ____	6. County ____
7. Case Manager _____		8. System _____	

9. Legal Custodian	_____
10. Date Referred to Accord	____/____/____
11. Age of Child at Referral Date	____
12. Reason for Referral	____
13. School Program	____
14. Adjudication Status	____
15. Developmental Disabilities	____
16. Mental Retardation	____
17. Health Condition	____
18. Child Abuse and/or Neglect	____
19. Behavior/Emotional Problems	____
20. Mental Health	____
21. Substance Abuse	____
22. Current Medications	____
23. Options Tried	____

... STARK COUNTY INTERAGENCY CLUSTER - 5/18/92 ...

**CLUSTER CHILD PROFILE
CODING GUIDE**

1

ITEM/DESCRIPTION/CODE

Gender

Male - 1
Female - 2

Race

Caucasian - 1
Black - 2
American Indian - 3
Hispanic - 4
Asian - 5
Pacific Islands - 6
Other (Bi-racial) - 7

County

Stark - 1
Other - 2

System

Mental Health - 1
Alcohol & Drug Addiction Services - 2
Special Education of Education Systems - 3
Mental Retardation/Developmental Disabilities - 4
Head Start - 5
Juvenile Justice - 6
Early Intervention - 7
Child Protection (DHS) - 8
Any Agency of the Child Serving Systems - 9

Reason for Referral

Funding - 1
Treatment Recommendations - 2
Both - 3

School Program

SBH (Severe Behavior Handicapped) - 1
L.D. (Learning Disabilities) - 2
M.H. (Multi-Handicapped) - 3
D.H. (Developmentally Handicapped) - 4
MR/DD (County Board Program) - 5
H.B. (Home Bound Instruction) - 6
Regular Classroom - 7
Hearing Impaired - 8
Other - 9
Alternative School - 10

Adjudication Status

None - 1
Abused - 2
Neglected - 3
Dependent - 4
Unruly - 5
Delinquent - 6
Other - 7

**CLUSTER CHILD PROFILE
CODING GUIDE**

2

ITEM/DESCRIPTION/CODE

Developmental Disabilities

None (For Ages 0-2)	- 1
1 Delay (For Ages 3-5)	- 2
2 Delays	- 3
3 Substantial Functional Limitations in 3 or More Skill Areas	- 4

Mental Retardation

Mild (IQ -> 69-55)	- 1
Moderate (IQ -> 54-40)	- 2
Severe (IQ -> 39-25)	- 3
Profound (IQ -> 24 & below)	- 4

Health Condition

None	- 1
AIDS/HIV	- 2
Autism	- 3
Birth Related Addiction	- 4
Cerebral Palsy	- 5
Cystic Fibrosis	- 6
Diabetes	- 7
Epilepsy/Seizure Disorder	- 8
Head Injured	- 9
Hearing Impaired/Deaf	- 10
Heart/Circulatory Disorder	- 11
Kidney Disorder	- 12
Neurological Impairment	- 13
Orthopedic Disorder	- 14
Speech Impaired	- 15
Spina Bifida	- 16
Tourettes Syndrome	- 17
Visually Impaired/Blind	- 18
Specific Learning Disorder	- 19
Other	- 20

Child Abuse and/or Neglect

None	- 1
Physical Abuse	- 2
Sexual Abuse	- 3
Emotional Abuse	- 4
Emotional Maltreatment	- 5
Neglect	- 6

**CLUSTER CHILD PROFILE
CODING GUIDE**

3

ITEM/DESCRIPTION/CODE

Behavior/Emotional Problems

None	- 1
Bedwetting	- 2
Bizarre Behavior/Language	- 3
Breaking/Entering	- 4
Eating Disorder	- 5
Encopresis	- 6
Enuresis	- 7
Fighting	- 8
Firesetting/Arson	- 9
Hallucinating/Delusional	- 10
Homicidal Ideation	- 11
Inappropriate Sexual Behavior	- 12
Problems w/Authority Relations	- 13
Problems w/Peer Relations	- 14
Robbery	- 15
Running Away	- 16
School Behavior Problems	- 17
Self-Mutilation	- 18
Sex Offender	- 19
Sleep Disturbance	- 20
Stealing	- 21
Suicide Attempts	- 22
Tantrums/Severe Anger	- 23
Truancy	- 24
Unwarranted Aggression/Assault	- 25
Vandalism	- 26
Withdrawal	- 27
Suicide Ideation	- 28
Other	- 29

Mental Health

None	- 1
Adjustment Reaction Disorder	- 2
Attention Deficit Disorder	- 3
Bipolar	- 4
Borderline Personality Disorder	- 5
Conduct Disorder	- 6
Depression	- 7
Dysthmic Disorder	- 8
Eating Disorder	- 9
Multiple Personality Disorder	- 10
Oppositional Defiant Disorder	- 11
Over-Anxious Behavior	- 12
Pervasive Developmental Disorder	- 13
Phobia	- 14
Schizophrenia	- 15
Other	- 16

Substance Abuse

Drugs	- 1
Alcohol	- 2
Both	- 3

**STARK COUNTY LOCAL CLUSTER FOR
SERVICES TO YOUTH - FUNDING AGREEMENT**

This Agreement made by and between those agencies comprising the Stark County local cluster for services to youth as established and designated in Ohio Revised Code Section 121.37(C), (hereinafter referred to as the Cluster) for the purpose of creating a systematic method of funding the provision of services to multi-need children on a non-categorized basis,

Witnesseth that:

WHEREAS, the Cluster has provided joint planning on behalf of children whose service needs require the resources of two (2) or more agencies which are represented on the Cluster, and,

WHEREAS, the Cluster has developed a vision statement together with driving principals to effect this vision and has developed a professionally based, clinically oriented process to identify the needs of children presented to it, and,

WHEREAS, the Cluster desires to implement a systematic method of funding services based on defined multi-agency participation levels,

NOW, THEREFORE, in consideration of the foregoing and the mutual promises hereinafter set forth the parties hereto agree as follows:

1. The Stark County Department of Human Services (hereinafter SCDHS), the Stark County Mental Health Board (hereinafter SCMHB), the Stark County Board of Mental Retardation and Developmental Disabilities (hereinafter SCMR/DD) and the Alcohol & Drug Addiction Services Board of Stark County (hereinafter, ADASBSC), as statutorily mandated

members of the Cluster (hereinafter collectively referred to as Core Agencies) will set aside a total of Three Hundred Fifty Thousand and no/100 Dollars (\$350,000.00) for the purpose of funding the service needs of appropriately determined children presented to the Cluster.

2. The Core Agencies will establish funds and appropriate thereto sums [based on percentages of Three Hundred Fifty Thousand and no/100 Dollars (\$350,000.00)] no less than:

forty-nine (49) percent for SCDHS;
thirty (30) percent for SCMHB;
twenty (20) percent for SCMR/DD; and
one (1) percent for ADASBSC.

No Core Agency is or shall be required to encumber any amount exceeding that set forth herein. Nothing in this Agreement, however, prohibits the contribution or further encumbrance of funds beyond the established levels as specific agencies deem best.

3. Each Core Agency hereby agrees to pay a proportionate share of the entire cost of services provided to each multi-need child, based on the percentages set forth below:

forty-nine (49) percent for SCDHS;
thirty (30) percent for SCMHB;
twenty (20) percent for SCMR/DD; and
one (1) percent for ADASBSC.

4.(a). Funding of services for a multi-need child presented to the Cluster by the ACCORD shall be determined by a vote of the representatives of the Core Agencies. Each Core Agency shall be responsible for appropriately designating its

representative. Each Core Agency shall have one vote. Three votes in favor of funding the services of a multi-needs child shall be required to bind the Core Agencies to the financial obligations agreed to herein.

(b). The representatives of at least three Core Agencies shall be present at any regular meeting of the Cluster to approve binding action on the funding of services of a multi-need child.

(c). Special meetings for the purpose of considering funding of services of a multi-need child shall not be convened without the concurrence of all four Core Agencies; however, at such a special meeting duly called, three votes in favor of said funding shall be required to bind the Core Agencies to the financial obligations agreed to herein.

5. Other member agencies participating in the Cluster may consider contribution on an case by case basis, considering the child's need and the services provided by that agency. These member agencies include, but are not restricted to, local and city school districts in Stark County, Health Departments in Stark County, the Family Court and Job Training Partnership.

6. Any contribution made by the aforementioned agencies referred in Paragraph 4 to the total cost of services provided to a multi-need child will cause an equal reduction in the contribution of the Core Agencies, which will pay the reduced balance in the same proportion as set forth above in paragraph 3.

7. The lead case manager identified for the child in need of service will pursue all other appropriate sources of

funds to the case, including, but not limited to, parental support, insurance, Medicaid, Social Security and SSI. Costs recovered from any one or more sources will be reimbursed to all contributing agencies, whether Core Agencies or non-Core Agencies, in the same proportion as their contribution bears to the total cost.

8. This Agreement shall be in effect for six (6) months, beginning January 1, 1992, and ending June 30, 1992. The parties agree to negotiate for the purpose of establishing a successor Agreement hereto, no less than sixty (60) days prior to the termination of this Agreement. This Agreement shall not take effect until it is executed by all the Core Agencies as set forth herein.

STARK COUNTY BOARD OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

By:

JOSEPH F. JAMES, SUPERINTENDENT

STARK COUNTY COMMUNITY MENTAL HEALTH BOARD

By:

A. LESLIE ABEL, EXECUTIVE DIRECTOR

ALCOHOL & DRUG ADDICTION SERVICES BOARD OF STARK COUNTY

By:

MARLIN K. PITCHFORD, EXECUTIVE DIRECTOR

STARK COUNTY DEPARTMENT OF HUMAN SERVICES

By:

DONALD K. POND, DIRECTOR

**APPROVED AS TO FORM
AND LEGAL SUFFICIENCY:**

DAVID M. BRIDENSTINE
Assistant Prosecuting Attorney

2/1/92

CLUSTER QI REPORT

MONTH/YEAR:

STARK COUNTY INTERAGENCY CHILDREN'S CLUSTER
QUALITY INDICATOR MONTHLY REPORT

SYSTEM REPORTING IN COUNTY/OUT OF COUNTY

LOCATION	DEPARTMENT OF HUMAN SERVICES		MENTAL HEALTH		MUNDO		FAMILY COUNT		ALCOHOL AND DRUG ADDICTION		UNDIFER- CATED NUMBERS	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
INPATIENT PSYCHIATRIC												
INPATIENT DRUG & ALCOHOL												
RESIDENTIAL TREATMENT												
RESIDENTIAL TREATMENT DRUG & ALCOHOL												
GROUP HOMES												
SHELTER CARE												
THERAPEUTIC FOSTER CARE ALL LEVELS												
FOSTER CARE												
MULTI-COUNTY ATTENTION CENTER												
DIRECT COST FOR CARE excludes admin cost												

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Profiles of Local Systems of Care

**for Children and Adolescents
with Severe Emotional Disturbances**

VENTURA COUNTY, CALIFORNIA

**Prepared By:
Sybil K. Goldman, M.S.W.**

**CASSP Technical Assistance Center
Center for Child Health & Mental Health Policy**

**Georgetown University Child Development Center
Funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)**

July 1992

INTRODUCTION

This case study was developed through a project conducted by the Child and Adolescent Service System Program (CASSP) Technical Assistance Center at Georgetown University. It is part of a descriptive study of local systems of care which was initiated in 1990 and funded by the National Institute of Mental Health (NIMH), Child and Adolescent Service System Program. The project has involved identifying and studying communities which have made substantial progress toward developing comprehensive, coordinated, community-based systems of care for children and adolescents who are severely emotionally disturbed and their families. Individual case studies of each local system of care are the products of this effort and are intended as technical assistance resources.

Systems of care for troubled children and adolescents have been of great interest over the last several years. In 1982, Knitzer estimated in her seminal study, Unclaimed Children, that of the three million children with serious emotional disturbances, two-thirds were receiving no treatment whatsoever and countless others were receiving inappropriately restrictive care because of the lack of community-based service alternatives. In 1986, Saxe conducted a study for the Office of Technology Assessment of the United States Congress which confirmed Knitzer's findings and stated that "Mental health problems are a source of suffering for children, difficulties for their families, and great loss for society. Though such problems are sometimes tragic, an even greater tragedy may be that we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available."

In response to these problems and to the growing number of calls for change, the National Institute of Mental Health launched the Child and Adolescent Service System Program (CASSP) in 1984 to assist states and communities in developing community-based systems of care for this underserved population. Through grants and technical assistance activities, CASSP has supported the development of interagency efforts to improve the services provided to the most troubled children and youth and their families. To provide a conceptual framework for system of care development, CASSP supported the publishing of A System of Care for Severely Emotionally Disturbed Children & Youth by Stroul and Friedman in 1986. This monograph has been called a blueprint for action in the child mental health field, and it describes the various service options required by these youngsters and the need for services across all of the relevant child-serving agencies. From these components, Stroul and Friedman proposed a design for a "system of care" encompassing both the full range of services and the mechanisms required for the assurance of their appropriate delivery. Currently, there is widespread agreement that community-based systems of care for youngsters who are severely emotionally disturbed and their families are needed, and the development of these systems has become a national goal.

Despite the calls for such systems of care, until recently there were few, if any, examples of local systems of care which combined an array of community-based services with other essential elements including interagency collaboration and case management. Today, there is what might be described as an explosion of activity related to system of care development. The activities of CASSP, which have now involved every state, have played a crucial role in stimulating system development at state and local levels. Increased attention to children's

mental health by advocacy groups also has had a major impact. Further, system building has been advanced significantly by initiatives such as the Robert Wood Johnson Foundation's Mental Health Services Program for Youth, which has provided funds for the development of systems of care in selected local areas, and extensive system development initiatives in a number of states. As a result, many communities now have evolving systems of care which can be studied and described. Descriptions of the system building approach and experience of these communities are designed to assist other communities which are attempting to develop such systems.

Potential sites for inclusion in this study were identified through a process of consultation with key informants including individuals at national and state levels who have extensive knowledge of developments in the children's mental health field and in the development of local systems of care in particular. Through these initial discussions, approximately 20 communities were identified. These localities were characterized as having made significant progress toward the development of community-based systems of care consistent with the philosophy and principles which have been promoted by CASSP and which are displayed on the following page. Accordingly, an attempt was made to locate local systems which are family focused, emphasize treatment in the least restrictive environment, involve multiple agencies, individualize services, and so forth. Similarly, an attempt was made to locate systems which have moved beyond the more traditional outpatient, inpatient, and residential treatment services and have begun to develop a more complete and balanced array of nonresidential and residential services including home-based services, day treatment, crisis services, therapeutic foster care, respite care, case management and others.

The second phase of the selection process involved extensive telephone interviews with a representative from each site to obtain detailed information about the array of services available in the community, the nature and functioning of the system level coordination mechanisms, and the nature and functioning of the client level coordination or case management mechanisms. In addition, information was collected about any special system activities related to such issues as financing the system, evaluating the system, involving families in planning and delivering services, and enhancing the cultural competence of the system of care. A chart was prepared for each potential site summarizing the service array, system level coordination mechanisms, and client level coordination mechanisms.

Selection of sites for further study was accomplished with the assistance of an advisory committee and was based on the following set of criteria:

1. Must have a range of services in place (home-based services, crisis services, therapeutic foster care, and others).
2. Must have interagency coordination mechanisms in place.
3. Must have client level coordination mechanisms in place, e.g., case management.
4. Must be a sufficiently well-developed local system to be able to serve as a useful example to the field and to receive national attention.

CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.
5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.
6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
10. Emotionally disturbed children should receive culturally competent services which are sensitive and responsive to cultural differences and special needs and are provided without regard to race, religion, national origin, sex, physical disability, or other characteristics.

5. Should have some noteworthy activities in one or more areas including family involvement, cultural competence, transition, high-risk children and adolescents, financing, and evaluation.

An initial group of five communities was selected for site visits by the project team. The site visits generally involved spending three to four days in each community engaged in a variety of activities designed to provide insight into the functioning of the system of care. These activities included interviews with a number of individuals and groups including key system managers, senior management representatives of the major child-serving agencies (mental health, child welfare, education, and juvenile justice), case managers, youngsters, parents, and advocates. Additionally, the schedules included visits to three or more service components in the system of care where activities were observed and discussions held with program managers, staff, and, in some cases, clients. An important aspect of the site visits was observing the functioning of interagency entities. Site visitors attended meetings of interagency entities focusing on system-level coordination as well as meetings of interagency teams organized for the purpose of creating individualized service plans for specific youngsters and their families. The site visits provided a wealth of information about each system of care -- its developmental milestones, strengths, and obstacles yet to be overcome.

The sample of communities studied yield valuable insights into the process of building systems of care. Due to an enormous increase in system development activities in communities across the nation, there currently are many more noteworthy examples of local systems of care. It should be emphasized that none of the communities selected for study have fully developed systems of care, and all are struggling to overcome financial and other obstacles to system development. Rather, they are communities which have succeeded in putting some basic building blocks into place and have demonstrated progress toward achieving system development goals. The resulting case studies are intended to serve as technical assistance resources for other states and communities as they approach the challenge of developing local systems of care for youngsters with severe emotional disturbances and their families.

REFERENCES

- Knitzer, J. (1982). Unclaimed Children. Washington, DC: Children's Defense Fund.
- Stroul, B. & Friedman, R. (1986). A System of Care for Severely Emotionally Disturbed Children & Youth. Washington DC: Georgetown University, CASSP Technical Assistance Center.
- United States Congress, Office of Technology Assessment. (1986). Children's Mental Health: Problems and Services - A Background Paper. Washington, DC: U.S. Government Printing Office.

PROFILE OF A SYSTEM OF CARE: VENTURA COUNTY, CALIFORNIA

I. COMMUNITY CONTEXT

Ventura County is a large, rapidly growing county on the southern California coast, between Los Angeles to the southeast and Santa Barbara to the northwest. Ventura County's population of 670,000 has nearly doubled in the last two decades; it is also highly mobile. The county is geographically rural, but most of its population lives in four cities: Ventura and Oxnard (225,000 collectively) on the west end, Simi Valley and Thousand Oaks (230,000 collectively) to the east. The remaining population is scattered in numerous smaller communities and rural areas across the county.

The county's diverse geography encompasses deserts, mountains, and beaches. Large tracts of land are still devoted to agriculture, but extensive new development of commercial centers, industry, and residences encroach on the neighboring fields of lush produce. Tourism has also developed along the coastline, which overlooks the Channel Islands. Further inland, the county is ringed by mountains, the Santa Monica Mountains to the south and the rugged San Raphael Mountains to the north.

Oil and agriculture are the chief economic bases. Ventura County ranks among the highest in oil production in California. It is also a manufacturing area for oil-related tools. The county is a major grower of citrus fruit, vegetables, and flowers as well as a center for raising poultry.

Ventura's population reflects some of California's diversity: 66 percent of the population is Caucasian, 27 percent Latino, 5 percent Asian American, and 2 percent African American. Less than one percent of the population is Native American, although the original inhabitants of the area were the Chumash Indians.

While Ventura's medium household income of \$45,612 is high, many of Ventura County's family incomes are at or fall below the poverty level. This is especially true for minority families. Forty percent of Latino families, seven percent of African Americans and five percent of the Asian families meet this poverty standard.

In mental health, as in many other arenas, California has been a leader. It was one of the first states to decentralize public services for people with mental illness when it passed the Short-Doyle Act in 1957, turning over responsibility for mental health services to its 58 counties. Legislation passed in the 1980s (AB 3920, AB 377 and AB 3777) has strengthened the county role in mental health by providing incentives to counties to serve mental health clients in community-based alternatives rather than state hospitals. In California, county governments are strong and exert a high degree of local autonomy over services and decision making.

In 1992, California initiated a policy called realignment which transfers resources for health, social services, mental health, alcohol and drug abuse from the general state fund to a local trust fund. This funding mechanism will provide counties with a greater degree of budget control and stability. Based on a formula, counties will receive funds generated from vehicle registration fees and from sales tax revenues. These funds can be used as local match for federal funds.

In Ventura, the following public-sector, child-serving agencies and the Ventura County Board of Supervisors are key players in the system of care.

Mental Health: Ventura County Mental Health Department, Division of the Health Care Agency

Child Welfare: Children's Services Department of the Ventura County Public Social Services Agency

Education: Office of Ventura County Superintendent of Schools and the Ventura County Special Education Local Plan Area (SELPA)

Juvenile Justice: Ventura County Corrections Services Agency (CSA)

Health: Department of Public Health, Child Health and Disability Prevention Program

Board of Supervisors: An elected body of five supervisors that develops and implements policy for the county.

The Ventura County Mental Health Department is divided into four sections: children, adults, seniors, and acute care. A 12-member management team, made up of senior administrative support staff and the chiefs of each of these sections, manages the operations of the Department. A mental health advisory board provides policy guidance to the Department.

II. BACKGROUND AND HISTORY OF SYSTEM OF CARE DEVELOPMENT

The history of the Ventura County system of care for children and adolescents who are severely emotionally disturbed has been an interesting process and demonstrates the importance of leadership at the community level, the building of coalitions, the "marketing" and timeliness of an idea, and support at the state level. As is so often the case, it is individuals with vision and strong leadership abilities who have been the catalyst to producing systems change. In Ventura, the combined forces of a member of the local Board of Supervisors, who is a special educator, and a social worker in the Mental Health Department (now the agency's director) provided the vision and brought together the necessary elements and support to achieve major systems change. According to the agency

director, the development of Ventura's system of care for children occurred in two phases -- from 1980 to 1984 and from 1984 to the present. The first phase consisted of the building blocks which led to the passage of legislation establishing the Ventura County Children's Mental Health Services Demonstration Project.

In the early 1980s, there was little support for children within the county Mental Health Department. The community mental health center was a traditional center, primarily serving "whomever arrived at the door first." Various providers and community leaders realized that this approach was no longer viable and that a broader system of support was needed, particularly for those children who were the most troubled. Too many of these youth were being sent out of county because of a lack of options in Ventura. During this time, a number of critical factors coalesced to facilitate change and create a new agenda for serving children with severe emotional disturbance. These factors included staff changes in the county mental health office including the arrival of the current Director of Mental Health (who initially was hired as a case manager); the election to the Board of County Supervisors of a new supervisor who was interested in and committed to youth; an activist judge in the community; and support at the state level for a new direction because of rising state hospital costs. The state was particularly concerned about the increased utilization of state hospitals for youth, since it was costing \$70,000 per year per child for a stay at the state hospital. As a result, there was a mutual interest at both the state and local level in exploring alternatives.

With state funding, the county Mental Health Department hired three case managers to work with those youth from Ventura County who were in state hospitals. The state mental health agency also agreed to exchange five county-designated state hospital beds for \$200,000 of flexible money to provide care to youth within the county. With those funds, the county developed a 16-bed psychosocial reeducation program to serve as an alternative to the state hospital. At this time, 14 Ventura County youth were hospitalized at Camarillo State Hospital, costing the state a total of one million dollars. The case managers gathered extensive information on each youth and determined that nine could be served in the community. These nine were transferred to the reeducation program.

Based on this experience, the county mental health program concluded that a gatekeeping system was needed to prevent unnecessary hospitalization and divert youth to community placements. The staff person mentioned above who eventually became the Director of the county Mental Health Department was assigned to review all Ventura youth referred to, or admitted to, the state hospital. Through this admissions review process, the county gained a much better understanding of the needs of youth who were being referred to state hospitals. During the period of 1982 to 1984, the state hospital census for Ventura County was reduced from an average census of 12 to 14 youth to 1 to 2 with no readmissions. With an investment of \$200,000 to establish the county-based reeducation program, overall costs for hospitalization were reduced from \$1 million to \$240,000. Another interesting side effect also occurred. Because a

number of the youth being referred to the state hospital were under the jurisdiction of Child Welfare, the mental health staff person assigned to review hospital admissions began to develop a relationship with the child welfare agency staff. The cooperation that developed provided the foundation for the building of trust between the two agencies.

The county also learned a number of lessons from this experiment: the community could serve children who are seriously emotionally disturbed; these less restrictive services were beneficial to the child and could result in cost avoidance; and the combination of benefitting children by serving them close to home and, at the same time, saving money was a powerful marketing tool to convince policymakers and providers that a new direction needed to be taken.

During this same time period that efforts were being made to divert youth from the state hospital, one of the local county supervisors who had a background in special education was also providing leadership for reform of children's services. For a year, under her direction, the Juvenile Court judges and the agency heads of Mental Health, Probation, Social Services, the schools, and the private nonprofit sector held regular brown bag lunches with resource experts to discuss issues related to children -- what services existed in the county, the gaps in services, the issues and problems of the different child-serving agencies, the differences in language and terminology used by those agencies and the mandates that directed them, and who were the multiproblemed youth the system was failing. These lunches led to the development of the Interagency Juvenile Justice Council and the Interagency Case Management Council.

The second phase in the historical development of Ventura's system of care actually began July 1, 1985, with the implementation of a critical piece of legislation, AB 3920, the Ventura County Children's Mental Health Services Demonstration Project, now referred to as the Ventura Planning Model. This pioneering legislation, enacted in 1984, integrated the legislative intent of numerous other federal and state statutes addressing public mental health services for children as shown on the chart on the following page. AB 3920 came about through an unorthodox alliance between those interested in cost containment and advocates for the improved quality of children's services. The legislation established a two-year demonstration project and directed Ventura to develop a model for a comprehensive, coordinated children's mental health system that could be replicated in other counties in California. The legislation was quite comprehensive in scope, and it specified interagency planning for children experiencing emotional disturbances that involved all publicly-funded agencies serving children; statutory and regulatory changes that would facilitate interagency cooperation; interagency protocols and agreements; appropriate services for difficult-to-place children, emphasizing services to children in their homes or in the least restrictive setting consistent with effective service delivery; and research to determine treatment effectiveness and cost-benefit. The state appropriated \$1.5 million for the first year to serve, in the community, those youth who would be at risk of out-of-home placements. In effect, these dollars were an exchange for serving youth in the county rather than paying for state hospital beds or unnecessary residential placement.

AB 377 Legislative Background

1. PL94-142, 1975 (Federal Law). Special Education. Assures that all handicapped children have a free and available public education that emphasizes special education and related services, including mental health.

2. AB3121, 1976. Juvenile Justice. Probation officer authorized to provide services to a child, including shelter care, crisis resolution homes, and counseling or education centers, in lieu of placement in secure custody solely because the child is described by Section 601, beyond parental control.

3. AB1339, 1978. Mental Health. Requires each county mental health service agency to allocate 50 percent of new funds to children's programs until amount expended is at least 25 percent of gross budget.

4. AB3052, 1979. Mental Health. Provided for a continuum of day care and residential treatment programs for children that would serve as an alternative to more costly and restrictive hospital placement.

5. AB1870, 1980. Special Education. Defines state responsibility for special education. For example, defines procedures for assessment of handicapped students, calls for placement in the least restrictive, defines psychotherapy as a "related service", and calls for written interagency agreements.

6. PL96-398, 1980 (Federal Law). Mental Health. Found that unserved and underserved populations remain, such as children and youth, who need mental health services. Priorities for SED (seriously emotionally disturbed) children include identification and assessment, availability of appropriate personnel, provision of mental health services for handicapped students, and cooperative arrangement with other agencies serving these children.

7. PL96-272 (Federal Law). Social Services. Directs reasonable efforts to be made to prevent "foster care drift" by eliminating the need for the child to return to his home or enter a permanent placement. Provides for case plans and timely review. Designed to limit temporary foster care to 18 months.

8. AB2315, 1981. Mental Health. Sought to develop a planning model for a continuum of mental health care for emotionally disturbed children that would promote appropriate treatment in the least restrictive and costly environment. Intended to prevent unnecessary state hospital and residential placement.

9. SB14, 1982. Social Services. California's interpretation of PL96-272. The court shall make a determination based on the provision of reasonable services to the child and parents/guardians that the child should be returned

or permanently removed from the home. Includes criteria for termination of parents rights. Designed to limit placement to 12 months.

10. AR2381, 1984. Mental Health. Legislative intent was to ensure the most cost efficient, flexible, and effective system of mental health programs possible, foster innovation and experimentation, and provide alternatives to institutional settings. Emphasized direct family work.

11. AB3632, 1984. Special Education. Intent was to maximize and coordinate state and local agencies serving handicapped children. Mental health is responsible for provision of related mental health services and lead case management and participates on IEP Teams when residential placement is considered. Diverts children from residential to non-residential services.

12. AB3920, 1984. Mental Health. Established a two-year demonstration project in Ventura County to design and implement a replicable, comprehensive, coordinated children's mental health system building on existing interagency services. Gave priority to services designed to keep child in usual family residence. Required evaluation for effectiveness of treatment and cost benefit on an ongoing basis.

13. AB2541, 1985. Mental Health. Omnibus legislation for all age groups. Mentally disordered children are a priority group, and families must be integrated in treatment plans when appropriate. County mental health has responsibility to assess court wards and dependents and determine the level of involvement to ensure access to appropriate treatment. Requires a county plan for a coordinated system of services for SED children.

14 AB2704, 1986. Mental Health. Identifies importance of mental health case management for children, and encourages development of these services for children separated from their families. Children's case management is defined differently from adult case management.

15. AB 377, 1987. Mental Health. Added measurable client and cost outcome goals to the Ventura County demonstration project and, when substantial compliance was achieved during the third year of the project, AB377 extended the Ventura Model to other counties, with availability of funding.

16. AB3777, 1988. Mental Health. Extended the Ventura Model to adults and seniors. Provided for four-year demonstration projects to evaluate the Ventura Model and Integrated Service Agencies, with availability of funding.

As will be discussed in greater detail in subsequent sections, Ventura was able to develop a comprehensive system and demonstrate initial findings that supported both treatment effectiveness and cost avoidance. At the end of the demonstration period, the governor signed a bill granting a three-year extension. With strong support from a broad-based coalition, AB 377 (known as the Replication Legislation) was enacted in 1987 to create a permanent structure for the Ventura children's system and to extend the Ventura Planning Model to other counties. In response to a request for proposal, three additional counties were selected to replicate the Ventura County Children's Mental Health Services Demonstration Project: San Mateo, Santa Cruz, and Riverside. In 1988, legislation was passed (AB 3777) to expand the Ventura model to serving adults.

At the state level, the legislation creating the local Ventura County system of care also requires the state Department of Mental Health to establish an advisory committee comprised of representatives from the state Departments of Education, Social Services, Mental Health, and the Youth Authority; representatives from the Conference of Local Mental Health Directors, California Council on Mental Health, County Welfare Directors Association, Chief Probation Officers Association, School Administrators Association; and a representative of the service providers from the private sectors. The function of the group is to advise and assist the state in the development of a coordinated, comprehensive service system of care.

III. PHILOSOPHY AND GOALS

The philosophical underpinnings for the Ventura Planning Model, determined in the initial developmental phase, were built into the enabling legislation and remain in statute. In the discussions that occurred between service providers, agency heads, and the community's political leadership, certain points of agreement and principles emerged. These tenets are: 1) that it is in the public's best interest to enable a high risk child to remain in his or her home or to be treated in the local community, and 2) that if a child must be removed from the home, local treatment prevents costly and restrictive residential and hospital placement. The premise on which the Ventura model is based is that a community-based, interagency system of mental health care which targets the most disturbed children will provide the greatest benefit to children, their families, and the community at the lowest cost to the public sector. By legislative statute, the Ventura County Demonstration Project was to demonstrate "cost avoidance" through the development of alternative in-county services.

The five essential elements of the Ventura Planning Model derive from this foundation. They are also considered to be generic principles, rather than specific program examples or models, that are applicable to other communities organizing systems of care. The elements also respond to the legislative mandate that Ventura establish a system that can be replicated in other sites. These elements, specifically delineated in the legislation, include:

- o A clearly defined set of targeted populations that include those youth who are at greatest risk of out-of-home placement and for whom the public sector already has legal and fiscal responsibility;
- o Measurable goals that are committed to the preservation of family unity and locally-based treatment;
- o The development of viable partnerships at the policy, planning, and service level between public sector agencies, between the public and private sectors, and between agencies and families;
- o The development of collaborative program services and standards that adhere to the service philosophy of family preservation, family reunification, and least restrictive environment -- developing service plans tailored to an individual child and family and having available a continuum of service options and settings that cross agency boundaries;
- o The development of a mechanism and process for system evaluation that measures client outcome and costs over time and across programs and ensures system accountability.

Client outcome objectives for the Ventura Planning Model are to enable youth who are severely emotionally disturbed to remain or be reunified with their families, to attend and progress in public schools, and to not commit crimes. Program development and evaluation are geared to the achievement of these primary objectives.

IV. TARGETED POPULATIONS

Determining the targeted populations for Ventura's system of care has been critical to the success of the program, but the very nature of defining a target population and narrowing the scope of those to be served creates controversy as well. As noted, definition of the population is one of five essential elements of the Ventura model. There are a number of important reasons for identifying the population to be served. These are to ensure public agency accountability, to achieve multiagency support, to focus limited public dollars on those most in need, and to enable program development to be appropriately tailored to the population to be served.

One of the first concerns was developing a definition that would be acceptable to the multiple agencies essential to the system -- Child Welfare, Education, Juvenile Justice, and Mental Health. The first three agencies all have mandates specifying the populations that they have a responsibility to serve. Since Mental Health does not have a similar mandate, these other agencies wanted to ensure that the population targeted for the service system would include the youth these

agencies are required to serve. The consensus was that the priority populations to be served by Ventura's system would include the following:

- o Those emotionally/behaviorally disordered court dependents whose histories include neglect, physical and/or sexual abuse, multiple foster home placements, residential treatment, and psychiatric hospitalization;
- o Those emotionally/behaviorally disordered court wards for whom the public sector has legal responsibility as a result of delinquent behavior and consequent court order who are at risk of out-of-home placement, i.e., residential placement, psychiatric hospitalization, and/or incarceration;
- o Those emotionally/behaviorally disordered special education pupils who require mental health services in order to benefit from their Individual Education Plan (IEP); and
- o Those emotionally/behaviorally disordered children who are not part of a formal agency other than Mental Health and are at risk of out-of-home placement into state hospitals or residential treatment.

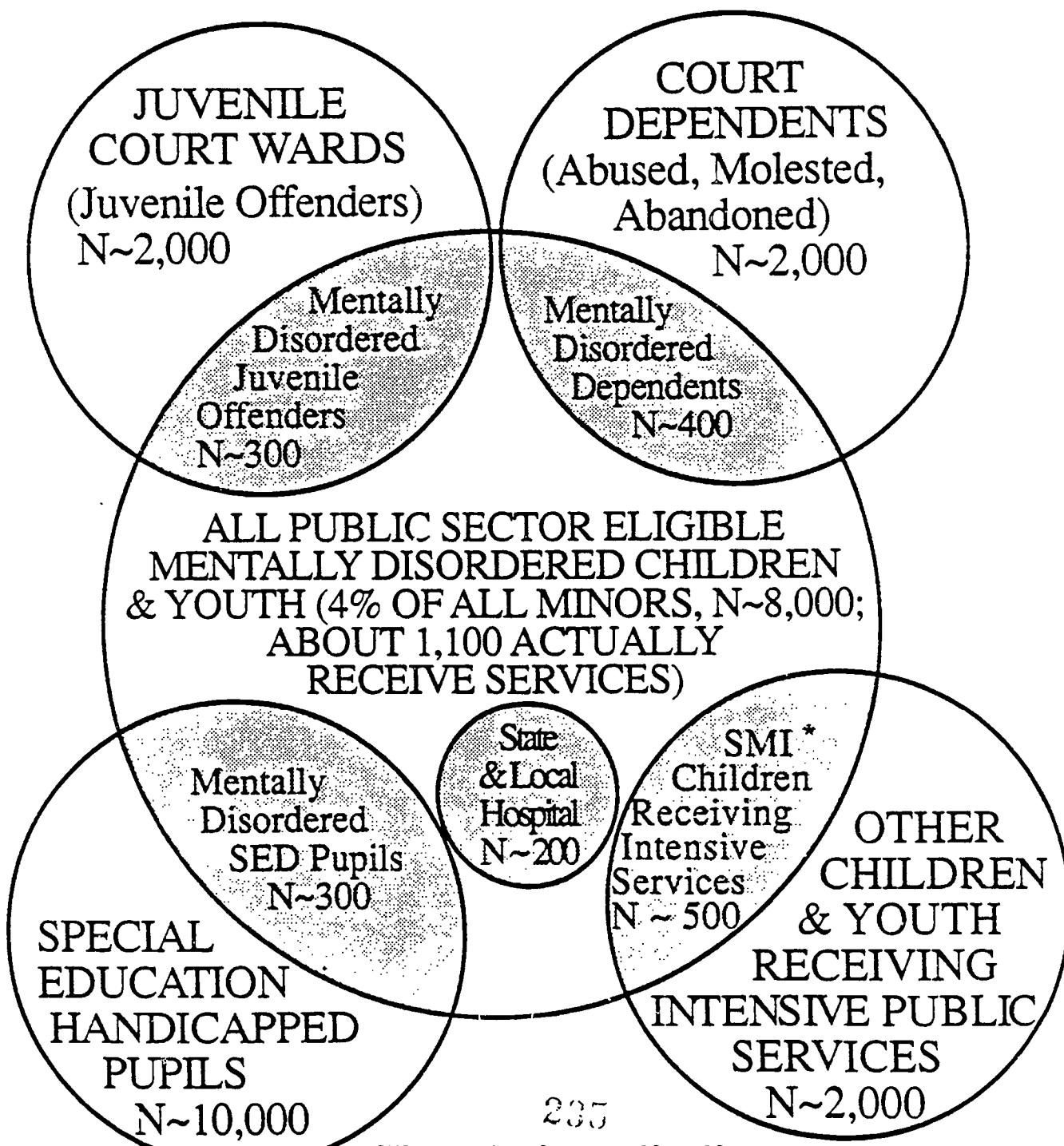
The diagram on the next page depicts those groups targeted in the Ventura model. The system's target populations are those in the shaded areas. Each of these target groups includes those at risk of entering that group. The numbers are projections based on the actual annual treatment caseloads for each group in Ventura County. Of the 1,700 youth designated as the target population at risk, 670 are served in the system at any point in time. A total of 1,400 receive services each year. Less than one percent of the children under 18 in Ventura County are included in the target population.

While it is often desirable for policy makers to target groups for fiscal reasons, it becomes difficult for clinicians to use those broad classifications in determining who of the many needy children they see should be given priority in receiving service. Thus, since the establishment of its initial definition of the target population, a special task force struggled for over two years to define specific target population criteria that can be used in daily practice. Descriptions of the target populations and criteria for including youth are shown on pages 10 and 11. The Mental Health Department has adopted the criteria and redirected all program staff and resources to serve this population of severely disturbed and high-risk clients. Ventura has also implemented a target review process and progressively discharged all nontarget clients, subject to clinical review for appropriateness. A survey of current clients indicates that more than 95 percent currently meet the target population criteria.

This narrowing of the population to be served by the Mental Health Department has raised concerns by some sectors about the elimination of early intervention activities that could prevent youth who are at lower risk from becoming more severely disturbed. If services are not available to youth at earlier, critical junctures, critics argue, their situation may become worse, increasing the likelihood that they will become members of the target population. While

THE CHILDREN & YOUTH TARGET GROUPS IN THE VENTURA MODEL

(Less than 1% of Ventura County Children under 18 are included in the Target Population)



*SMI = seriously mentally ill

WHO WILL RECEIVE PRIORITY -THREE FACTORS

1. Risk

Children at greatest risk with a mental disorder should receive priority for limited tax supported local mental health services.

A Governor and Legislators concerned about the future have an interest in redirecting the lives of children at greatest risk of becoming dysfunctional adults. Studies of today's incarcerated, homeless, chronically unemployed, and institutionalized adults reveal childhood and school histories of severe family conflict and breakdown, physical and sexual abuse, delinquent behavior, and school failure and dropout. In these histories parents and teachers report unpredictable, impulsive, aggressive or destructive behavior, or depressed, withdrawn, isolated, and strange behaviors. These patterns are frequently manifestations of severe childhood mental disorders though few of these dysfunctional adults received any appropriate mental health treatment as children.

Early and premature separation from the family is a critical and usually irreversible event in their lives as children. Bouncing between divorced parents, multiple foster home placements, residential treatment placements, psychiatric hospitals, state hospitals, and incarceration in juvenile justice facilities were frequently part of the downward whirlpool cycle for these adults. Separation from family both reflects clinical severity and adds risk to the tenuous and damaged child's hope for the future. Even necessary separation adds risks for these children's chances to regain a place in their family, school and community.

2. Legal Responsibility

Mentally disordered children with existing public agency legal responsibility should receive priority for limited tax supported local mental health services.

When government by the action of a Superior Court Judge or other Court Officer for protection or due to delinquent behavior takes legal and/or physical custody of a child from a parent, it assumes an awesome and heavy legal responsibility for that child. When a court ward or dependent has an identified mental disorder the Judge has a legal responsibility and obligation to provide appropriate mental health assessment and treatment.

Under Federal Law PL-94-142, handicapped students have a right to receive an appropriate education at no cost to their parents. As part of an appropriate education special education pupils are guaranteed mental health services "related" to their education as part of their individualized education plan. This law clearly establishes a legal responsibility and obligation to provide mental health services in these instances.

3. Fiscal Liability

Mentally disordered children who for lack of appropriate mental health services pose the greatest financial liability to the public should receive priority for the limited tax supported local mental health services.

Public agency programs, including Special Education, Child Protective Services, Juvenile Justice and Mental Health provide a continuum of services in graduated levels of restrictiveness and cost. Untreated, seriously emotionally disturbed children fail at less restrictive levels of service and "graduate" to more restrictive and expensive levels. Foster home failures, special education class changes and failure, and probation violations, lead eventually to residential treatment placements, local and state hospital admissions, or incarceration. Tax supported residential placements range from \$25,000 to \$75,000 per year, Medicaid and State psychiatric hospitals from \$100,000 to \$200,000 per year and incarceration about \$25,000 per year.

A system of less expensive local mental health services targeted to children separated or at imminent risk of separation with the goal of family maintenance or reunification can offset a major portion of the cost by reducing the number of children and length of stay in 24-hour facilities.

Ventura Planning Model Target Populations

MENTALLY DISORDERED CHILDREN & YOUTH

Must Have (I, II & III) OR (I, II & IV) OR V:

I. Diagnosis

DSM III-R Axis I or II diagnosis, except a primary diagnosis of Psychoactive Substance Use Disorder, Developmental Disorder, or V Code. Organic Mental Disorders are included only while behaviors are a danger to self or others.

II. Risk of or Separation from Family

Risk of or separated from family due to, for example: (1) Chronic family dysfunction involving a mentally ill and/or inadequate caretaker, or multiple agency contacts, or changes in custodial adult; or (2) going to, residing in, returning from any out-of-home placement, e.g., psychiatric hospital, short-term inpatient, residential treatment, group or foster home, corrections facility, etc.

III. Functional Impairments/Symptoms

Must Have A OR B:

A. **Functional Impairment.** Must have substantial impairment in two of the following capacities to function (corresponding to expected developmental level):

1. Autonomous Functioning.
2. Functioning in the Community.
3. Functioning in the Family or Family Equivalent.
4. Functioning in School/Work.

B. **Symptoms.** Must have one of the following:

1. Psychotic Symptoms.
2. Suicidal Risk.
3. Violence: At risk for causing injury to person or significant damage to property, due to a mental illness.

IV. History

Without treatment there is imminent risk of decompensation to Risk of or Separation from Family in Section III, above.

V. Special Education Eligible Under Chapter 26.5 of the California Education Code (AB 3632).

All Ages: Victims of an officially declared natural disaster or severe local emergency.

Draft Revised March 13, 1992

agreeing that this is a problem, Department leadership believes that since public resources are not sufficient to serve everyone, resources must be targeted to those most in need. The definition and criteria developed are intended to guide that decision-making and triaging process. The rationale is that fewer people will be served better. This strategy also can be applied successfully to developing systems of services for other populations. Targeting the high end of the spectrum in cost and utilization may also provide justification for additional resources to support prevention and early intervention activities.

V. ORGANIZATION OF THE SYSTEM

System Management

Ventura County has taken a unique approach to developing a system of care. The key to understanding the Ventura system is understanding the role the Mental Health Department plays and its position vis a vis the other child-serving agencies. The basic concept is that mental health services are integrated into the service systems of the major child-serving public agencies -- Juvenile Justice, Special Education, and Child Welfare. Mental health services go to where the child is. This has not only proven to be better for children and families, but also has created a change in how each of the agencies carries out its work. Agencies now function differently even when Mental Health is not directly involved with a child.

The architects of the Ventura model believed that a service system for youth must involve all the major child-serving agencies and must provide an array of services that will enable youth, when appropriate, to remain in the county and in their homes. At the same time, there was the recognition that the state has legal mandates for different youth, and the agencies charged to carry out these mandates are often limited by specific eligibility criteria, laws and regulations dictating their responsibility to the target population. Across the country, these mandates, while a protection to youth, have also served as barriers to developing more integrated, comprehensive service systems. The Ventura approach deals with the realities of different agency mandates and eligibility policies.

In the Demonstration Project (AB 3920), the Mental Health Department uses its fiscal and staff resources to provide the service components that would enable youth to be served in the county in the least restrictive setting. By integrating mental health services into each system, there is less need to refer a youth to a state hospital or residential treatment center to obtain needed mental health services. The "intensity" of the service provided in the community can serve as an alternative to more restrictive placements. In Ventura, the method of interagency integration varies by service system. Roles and relationships are delineated in interagency agreements. Mental Health serves as the system's core and provides specialized services to each system -- Juvenile Justice, Child Welfare, and Special Education. These services are described in more detail below.

In addition to interagency agreements which spell out joint administrative, fiscal, and service responsibilities, the Ventura County system of care is linked through several key interagency coordinating mechanisms as shown in the diagram on the next page. The Interagency Juvenile Justice Council is a policymaking body made up of all the public agency directors and the judges. The chair of the Council is the presiding judge of the Juvenile Court. The Interagency Case Management Council is the vehicle for case resolution and the identification of service system gaps and problems. The Case Management Council consists of agency representatives who have the authority to commit resources for each public service agency.

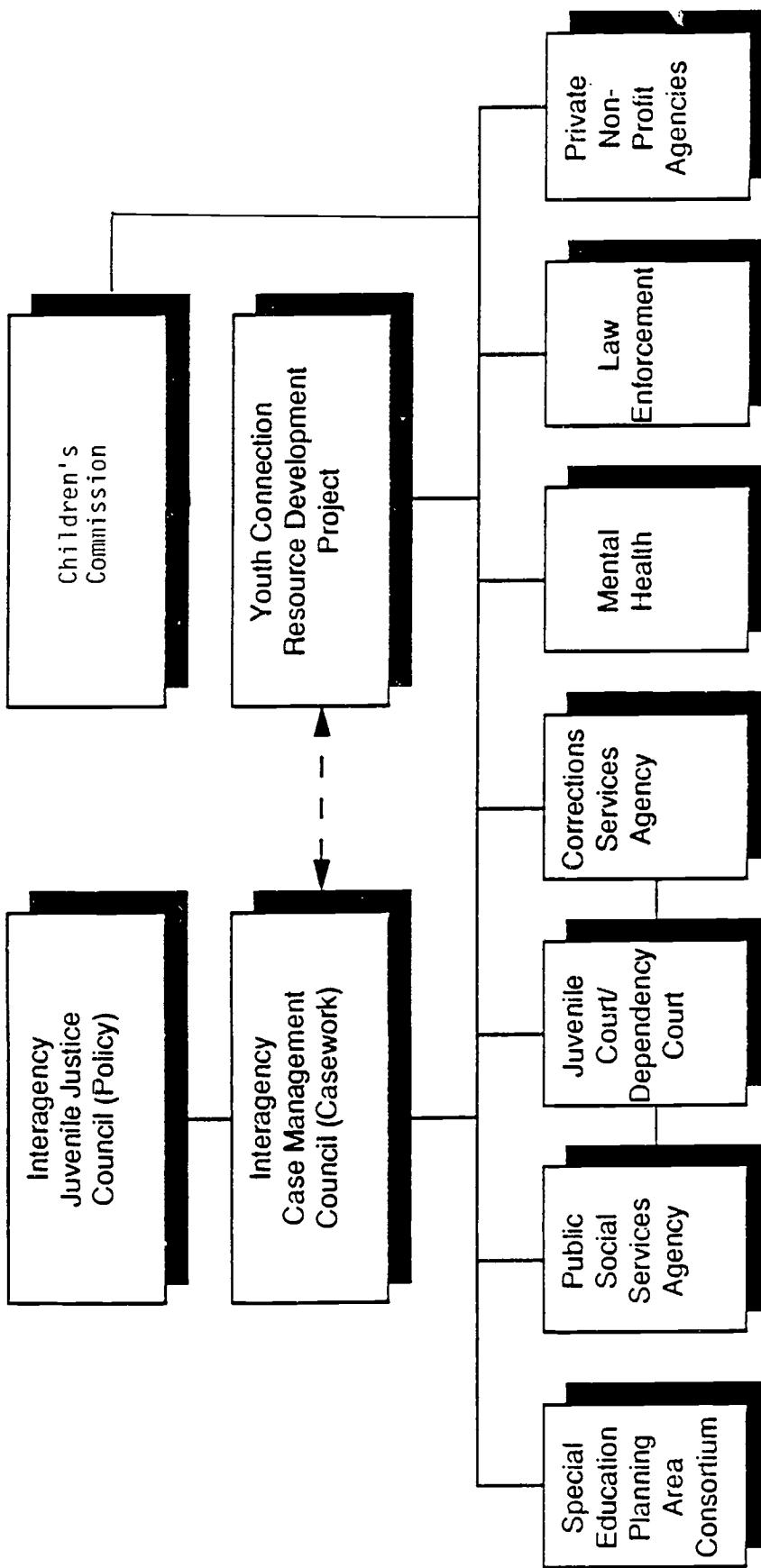
Role of Participating Agencies

- o Mental Health: Ventura County Mental Health Department, a Division of the Health Care Agency

As indicated in the section on the developmental background of Ventura's system, the Mental Health Department has undergone some significant changes in the decade of the 1980s. Initially the Department was organized under a director and reporting to him were three regional managers. There was also a separate children's division that included nine outpatient therapists. The Demonstration Project, when it was started, was a separate initiative with its own budget, staff, and project director who reported to the Director of Mental Health. As the Demonstration Project evolved, it took on a life of its own and in some ways overwhelmed the Department. In 1987, the project's status as a "demonstration" ceased. Since that time several major reorganizational changes have occurred within the Department. The former director of the Demonstration Project is now the Director of Mental Health for the county. The staff and programs of the previous Demonstration Project are fully integrated into the Department, and the outpatient children's services are converting their mission to serving the target population. One of four sections within the Mental Health Department is now devoted to children. The Children's Section includes a Chief of Children's Services and supervisors for Case Management, Special Education, Child Protective Services, Juvenile Justice, and Outpatient Services. Staff also include a medical director and research psychologist.

The Mental Health Department served as a catalyst in the development of the system of care and works in concert with the other child-serving agencies. As indicated above, roles and responsibilities are delineated in interagency agreements. Interagency mechanisms exist for planning purposes and for problem resolution. However, to understand how the system functions as a whole, it is useful to examine how Mental Health relates to and works with each agency individually. It is also important to contrast the situation before and after the Demonstration Project. These relationships are explicated in the discussions of each of the key participant agencies in the system of care.

Ventura County Interagency Network



In the Ventura system of care, mental health staff work in settings within Education, Child Welfare, and Juvenile Justice. The Mental Health Department provides an intensive outpatient service and a clinically-oriented case management unit that serves as a "broker" to the system. Mental health staff serve as a liaison to each of the three major systems and supervise the mental health clinical staff working in that setting.

o Juvenile Justice: Ventura County Corrections Services Agency (CSA)

In Ventura County there are two full-time judges for youth, dealing respectively with delinquency cases and dependency cases. By county policy, judges normally rotate every two years. The Corrections Services Agency (CSA) operates the existing programs for youth within the juvenile justice system. A number of these programs are conducted through the interagency efforts of Mental Health and the Ventura County Superintendent of Schools. The three local institutions consist of the Clifton Tatum Center, which is the Juvenile Hall, an 84-bed maximum security setting for pre-and post-dispositional minors; the Colston Youth Center, a 45-bed medium security residential facility; and the Juvenile Work Release Program, a 24-bed minimum security facility. Wards of the court are also sometimes ordered into "Suitable Placement," which encompasses the following: residential treatment centers (out-of-county), group homes (in-and out-of-county), small family homes (in-county), and foster homes (in-county). The funding for all of the "Suitable Placement" services is through Aid to Families with Dependent Children (AFDC). Wards of the court may also be ordered home on probation and assigned to deputy probation officers located in three main field service sites in the county.

Approximately 2,000 youth go through the juvenile justice system annually, with CSA providing an array of services ranging in restrictiveness from delinquency prevention and youth services, informal probation, formal probation, removal of youth from their homes to commitments for a small percentage of youth to the California Youth Authority. Although mental health services might be appropriate for a vast majority of these youths, resources have been concentrated to serve the highest risk youth, those who have the most serious delinquency histories and also the most serious mental health problems. The cornerstone of the Demonstration Project, and still the largest program in the juvenile justice system, is the Colston Youth Center. Youth are committed there for four-to six-month periods. The program is operated on an interagency basis with CSA, Mental Health, and the Superintendent of Schools. Mental health services are also provided at the Clifton Tatum Center, but these are limited to suicide risk assessment, crisis intervention, and brief therapeutic interactions. The limited mental health resources in the county have been designed to be placed in treatment settings where the highest impact is likely to be felt.

Since the Demonstration Project, there have been several new additions to the services within the juvenile justice system. One of these is the Visions Interagency Program (VIP), a three-day-a-week day treatment school serving wards and dependents of the court. This is also operated on an interagency basis with CSA, Mental Health, the Superintendent of Schools, and Children's Protective Services. In addition, the Forensic Adolescent Program (FAP) provides long-term (approximately 18 months) outpatient services to juvenile sex offenders. The youth might be committed for some amount of time to the Colston Youth Center, a local group home setting, or home on probation in order to receive the individual, group, and family therapy services provided by FAP. The FAP mental health staff also provide evaluations to the court regarding the amenability of youth to juvenile sex offender treatment.

Currently there is one mental health supervisor for the juvenile justice system, five full-time equivalent (FTE) mental health staff at Colston, one FTE providing aftercare services to Colston residents, approximately one FTE providing services at Clifton Tatum Center, two FTEs at VIP, two FTEs at FAP and three case managers. The system of care for mentally disordered juvenile offenders is outlined in the diagram on the next page with bullet points designating the mental health services provided.

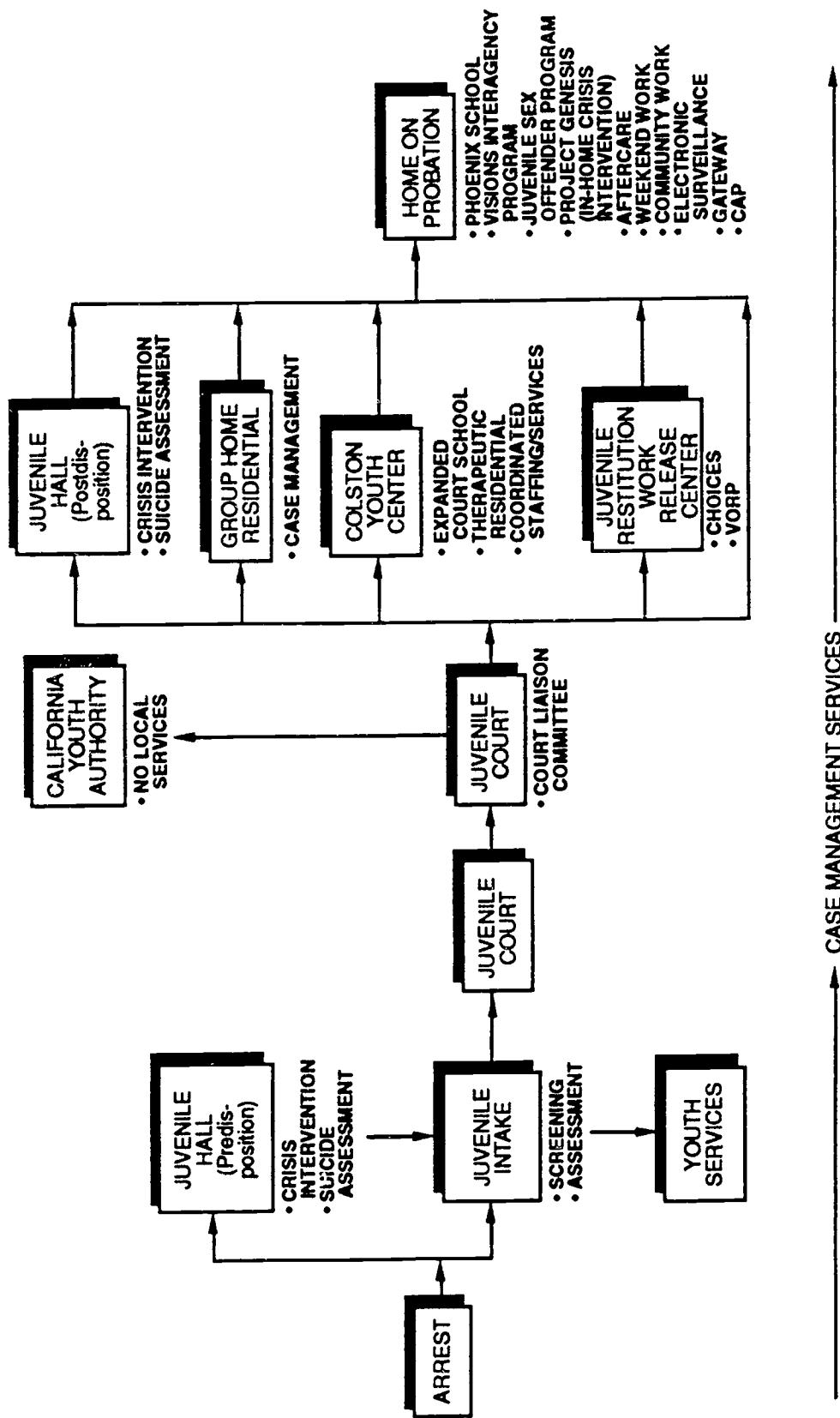
- o Child Welfare: Children's Service Department of Ventura County Public Social Services Agency

Mental Health plays multiple roles in the child welfare/protective service system as shown on the diagram on page 18. The "Shomair" team is the centerpiece for the mental health component within the child welfare system. Shomair is the Hebrew word for guardian, meaning one who protects and watches over others.

Shomair staff provide major services to children and youth who have been physically or sexually abused, neglected or abandoned, and who have been removed or are at risk of removal from their homes by the court. The Shomair team interfaces with three different facets of the Child Welfare Division; Children's Protective Services (CPS) staff, foster families, and the children placed in foster care or temporary shelter care. Shomair staff consist of six mental health professionals, all of whom have developed great expertise in the child welfare system. The mental health staff have an office at CPS, are highly visible and available to child welfare staff, and are fully integrated into the child dependency process. Specifically, the Shomair team is involved in assessment and treatment planning, in the enriched foster care program, in collaborative foster parent recruitment and training programs, and in the placement screening committee process.

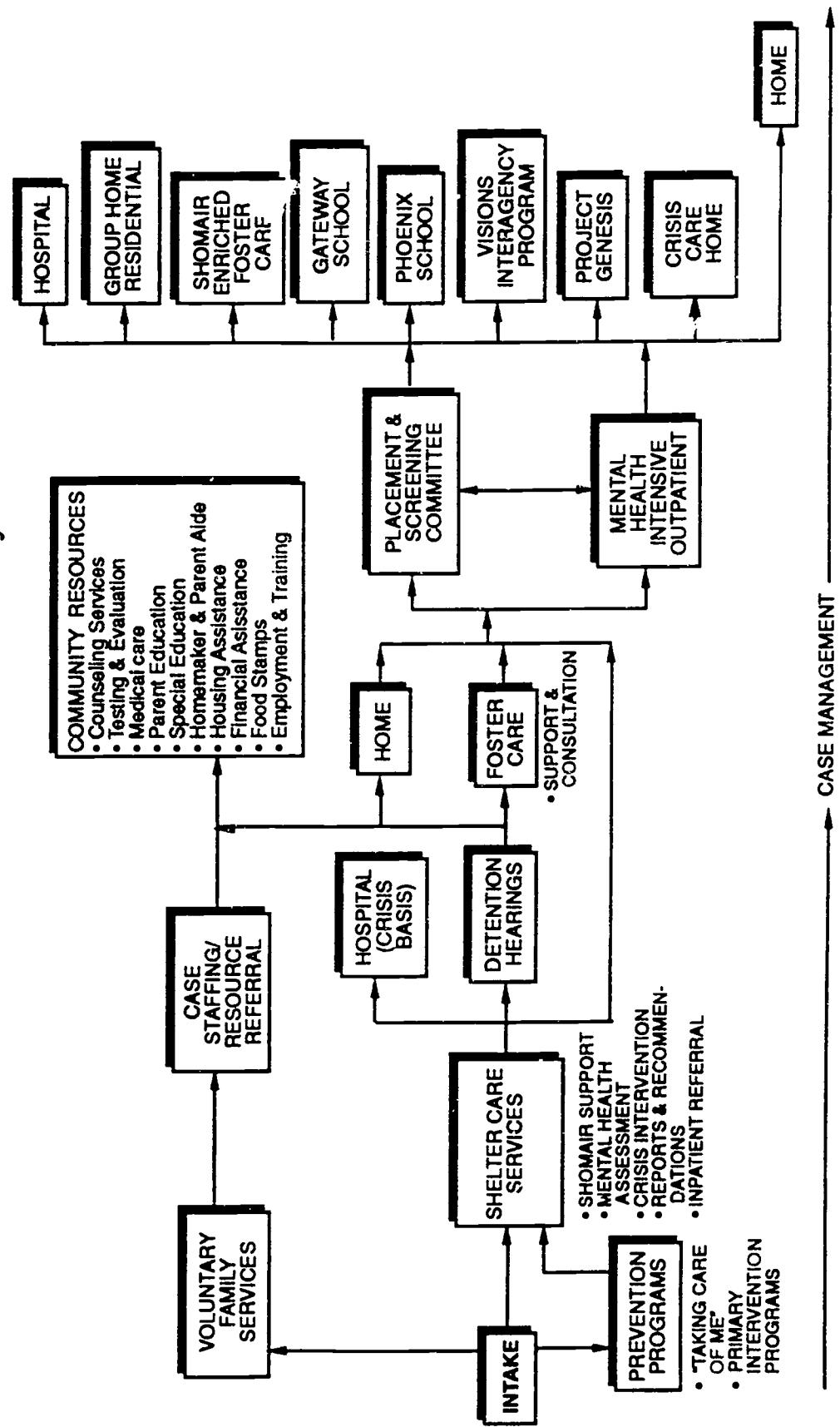
All children entering shelter care (temporary foster protective custody) are assessed by the Shomair staff within 72 hours. In Ventura about 35 youths per month come into shelter care. Assessment includes evaluation of the

Juvenile Corrections Sub-System



Flow charts developed by Dr Daniel Jordan, Systems Evaluation, Ventura County Mental Health.

Child Protective Services Sub-System



Flow charts developed by Dr Daniel Jordan, Systems Evaluation, Ventura County Mental Health.

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child for suicidality and depression, identification of placement and treatment needs, crisis intervention, and provision of consultation and recommendations to the shelter parents. This information is provided to the CPS court worker prior to the initial dependency and jurisdictional court hearings.

The Shomair staff provide intensive services to about 28 children in enriched foster care. The Shomair therapist becomes the therapist/case manager for the child and for the entire foster family. Mental health staff coordinate their efforts with the CPS social worker, the biological family, and school and day-care staff. They also provide follow-up care for six months after the child returns home. One Shomair staff person is dedicated to working collaboratively with CPS personnel in the recruitment of foster parents. Specialized training and support groups for foster parents within the Shomair program are offered by this individual.

In addition, mental health and child welfare staff share responsibilities in decision making in a weekly placement/screening committee. This committee, which is comprised of Shomair staff, senior CPS staff, and other appropriate agency personnel, reviews all requests for changes to a more intensive placement (e.g. to enriched foster care, a group home, residential treatment, or hospitalization). A unique placement and treatment plan is developed for each child presented to the committee. Most children returning to less restrictive care are also presented to the committee for suitability and appropriate treatment/living plans when the child reenters the community.

- o Education: Office of Ventura County Superintendent of Schools and the Ventura County Special Education Local Plan Area (SELPA)

Ventura County has 20 local school districts and one county school district for special populations. Each school district has its own superintendent, special education unit, and school board; the 21 superintendents from these school districts form a policy-making board. Each region has a coordinator for special education services who reports to this board through a special education coordinating body. All the special education units are coordinated under the Special Education Local Plan Area (SELPA). There are a total of 117,000 pupils in Ventura County, and 12,000 are in special education. According to school standards, 293 of these students are designated seriously emotionally disturbed, but according to mental health staff, the number who are seriously emotionally disturbed more closely approximates 500 based upon 1986 estimates.

California has a unique piece of legislation, AB 3632 (Chapter 26.5), that addresses the problem of mental health versus educational and local services' fiscal responsibility for special education students who require mental health services as part of their Individualized Education Plan (IEP) or out-of-home placement. According to this legislation, students identified as requiring special education are also entitled to appropriate

mental health services, if necessary for the student to benefit from the IEP. This legislation requires that local mental health agencies provide case management for children who receive residential services.

Since the Demonstration Project, the relationship between Mental Health and Special Education has changed, and, as with other key child-serving systems, Mental Health now plays a critical collaborative role. Before the Demonstration Project, therapists in the mental health system did not know how many or which youth served in outpatient services were designated as special education students. Now Mental Health is fully integrated into the special education process. Entry into the mental health/special education system, outlined in the diagram on the following page, requires assessment by both agencies. The mental health professional who conducts the assessment becomes part of the student's IEP planning team. Through the Demonstration Project, a number of service options -- from least restrictive first choice service options to more restrictive second choices -- have been developed combining staff and funds of Mental Health and Special Education. Under the first choice, local alternative programs, youth can remain in their local schools receiving supportive mental health services that are part of the Ventura system (such as outpatient, intensive outpatient, and in-home services) in conjunction with special education programs (such as day classes and resource specialists). Two local day treatment programs for high school and elementary students (the Phoenix School and Elementary Program) have been established and are costaffed by Mental Health and Special Education. Enhanced special day classes on regular school campuses have also been established and are staffed by both mental health professionals and special education teachers. Only those students who have exhausted all local, less restrictive options are referred to residential programs. These youth are placed by the mental health case manager who works through the IEP process with the school district and family.

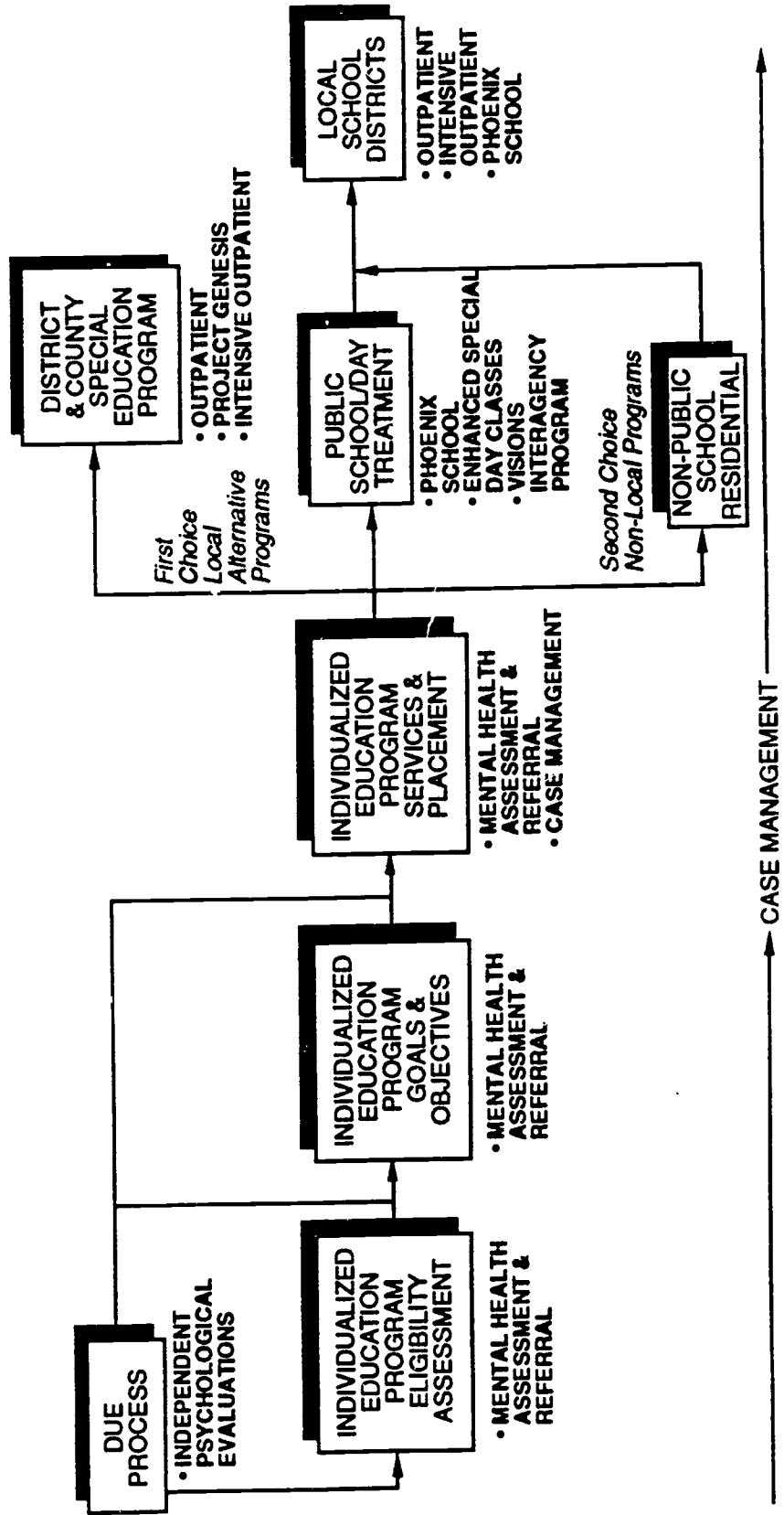
On an administrative level, mental health management staff work cooperatively with special education managers and attend SELPA meetings (comprised of all special education directors) for information exchange, education, problem resolution, and service planning.

o Private Sector

One of the essential elements of the Ventura County system is interagency collaboration between the public and private sectors. This collaboration is accomplished through a number of private/public sector boards, the recently established countywide Children's Commission, the Resource Development Project, and service contracts with private nonprofit agencies, particularly Interface, a private not-for-profit umbrella agency offering multiple child-serving programs.

One of the unique components of the Ventura Planning Model is the Resource Development Project, which operates a bank of goods and

Special Education Sub-System



Flowcharts developed by Dr. Daniel Jordan, Systems Evaluation, Ventura County Mental Health.

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2021

services donated to assist youth. Services include private counseling, psychological evaluations, dental services, dance lessons, and tutoring. Goods include clothing, recreational equipment, and school supplies. Their value is worth approximately \$1 million. The Resource Development Project is operated and staffed by Interface, with initial start-up costs to get the project underway supported by the United Way. A resource list of available goods and services is sent to agencies monthly. Agencies, in turn, make requests for specific youth through a standardized intake form, and a match is made. More than 400 children have been served to date through this exchange.

VI. SYSTEM OF CARE COMPONENTS

Through the various targeted populations and resultant interagency partnerships, Ventura County Mental Health's "system of care" is organized by three sub-systems of care and two service modalities. The three sub-systems include: Juvenile Justice, Child Welfare, and Special Education. The service modes that cover all of the systems are the outpatient program and case management. As noted, within each sub-system is an array of services. The chart on the next page outlines this array of services across the sub-systems.

In addition to the system of core services provided in conjunction with Mental Health, there are other services and programs offered by the major public child-serving agencies. Although Mental Health is not directly involved in all service delivery, the CASSP principles are evident in each agency. This section focuses on those services with which Mental Health is involved.

Prevention

While the Ventura County system focuses on the most high-risk youth, it has undertaken a primary prevention program for young children. The Primary Intervention Program (PIP) is a school-based program modeled after the highly successful and well-researched Primary Mental Health Project in Rochester, New York. It is designed to help students settle into the school environment by assisting young children (grades kindergarten through third) who are experiencing difficulties in peer relationships, are shy, are overly active in the classroom, or have learning problems. The program's goals are to help children get a good start in school by fostering healthy self-concepts, developing social skills, and bringing school work up to potential to prevent the need for more extensive specialized help in the future.

Once a child is accepted into the program, after screening and referral, a trained and supervised child guidance assistant dedicates 30 minutes once a week for 12 to 15 weeks to work with the child individually in a specially designed and equipped playroom. The Primary Intervention Program is funded for three years through the Mental Health Primary Prevention Fund, a fund made possible by confiscated drug monies. It is a cooperative effort between the Ventura County

VENTURA COUNTY MENTAL HEALTH CHILDREN AND ADOLESCENT PROGRAM

Array of Services

Flexible dollars can be used across programs.

- Element 1.** Prevention
 - Consultation, Education, Information Services
 - Primary Prevention Project
- Element 2.** Emergency Service
 - Outpatient Crisis Service
 - Genesis Outreach
 - Case Management
 - Shomair Shelter Care Interventions
 - Juvenile Hall Crisis Intervention (Clifton Tatum Center)
- Element 3.** Outpatient
 - Ventura - Santa Paula - Ojai
 - Oxnard - Camarillo
 - Simi - Conejo - Moorpark
 - Forensic Adolescent Program
- Element 4.** Enhanced Special Day Care Classes
- Element 5.** Day Care
 - Phoenix School
 - Phoenix Elementary Program
 - VIP Day Care
- Element 6.** Case Management
 - Countywide
- Element 7.** Crisis Intervention Homes
 - Crisis Intervention Home (6 beds)
- Element 8.** Enriched Foster Homes
 - Shomair Homes (25 placements)
- Element 9.** Transitional Residential
 - Colston Youth Center (45 beds)
 - Santa Rose Treatment Home (4 beds)
- Element 10.** Acute Psychiatric Hospital
 - Adult Inpatient (children, adolescents integrated with adults)
 - Contract Arrangement with Private Psychiatric Hospitals
- Element 11.** Long-Term Residential
 - Private Title AFDC Group Homes -- Within and Out-of-County
- Element 12.** Secure Regional Intensive Treatment Center
 - Camarillo State Hospital, Child and Adolescent Program (6 beds)

Mental Health Department, the state Department of Mental Health, and the school districts. Currently, there are four school districts and a total of 12 schools involved in the program serving 576 children. It is anticipated that in 1992-93, the program will be expanded to additional schools and another school district resulting in approximately 672 children being served in Ventura County.

Intensive Short-Term Intervention

- o **Project Genesis** is a home-based crisis service which is operated by Interface, a local, nonprofit social service agency, through a contractual arrangement with the Ventura County Mental Health Department. This intensive intervention program intervenes with families in which the emotional and behavioral problems exhibited by one or more of the children have escalated into an acute crisis and out-of-home placement is imminent.

Services are delivered primarily in the family's home over the course of six weeks. In addition to the average of 12 to 15 hours per week of contact, each family is provided 24-hour emergency on-call services from the program and a two-week transition process into ongoing care. The program, in existence since 1986, has been providing services to over 50 families each year. Referrals are restricted to acute crises where out-of-home placement is the only available option, and the intervention is coordinated by the children's mental health supervisor in each of the child-serving sub-systems. Initial contact with the family is made by the program within 24 hours.

- o **Clifton Tatum Center (CTC)** - Mental health services at Juvenile Hall comprise six-day-a-week coverage for crisis intervention and suicide risk assessment. Each youth entering Juvenile Hall is assessed by the corrections services staff as well as the medical staff, and these written assessments are reviewed by Mental Health. At that time, mental health issues are identified and followed up by mental health staff. Youth on suicide status are seen daily by Mental Health. Staff may also refer youth to Mental Health, and youth themselves can request to see mental health staff. Mental health staff provide ongoing consultation and informal training to corrections services as well as to school staff at the Clifton Tatum Center. Although there is no in-depth therapy for youth at CTC, due to their vulnerability at the time of incarceration and the excessive stress of incarceration, there is a great need for ongoing evaluation and support for some of the youth during their stay at Juvenile Hall.

Outpatient Services

- o **The Options Program** - Outpatient services are provided solely by the Mental Health Department and are organized on a regional basis. During the evolution of the Ventura Planning Model, the outpatient service system of the Department has been dramatically changed. The hallmark of Ventura's outpatient delivery system is its integration with the other

service systems and its focus on the target populations. As indicated in the diagrams on pages 17, 18, and 21, outpatient services are one of the treatment components of the Juvenile Justice, Child Welfare, and Special Education sub-systems of care. In addition, the Options Program is the primary source of entry and emergency contact for the community at large.

Using the Ventura County functional assessment criteria shown on page 11, the outpatient service staff, through a combined system of phone and in-person screening, assess the client's situation. A triage committee then decides whether to accept the client or refer elsewhere. Approximately 70 to 80 percent of those screened are referred to other agencies or practitioners for service. If the client is accepted for service, services could include individual and family treatment in an office setting or in the youth's home, parent consultations, and consultation and collaboration with other agency staff.

Despite these changes in doing business, outpatient services in Ventura remain in transition. Staff struggle with turning away clients who could benefit from service but who do not meet the criteria for the target population. The number of families who are accepted for service and the extent of their needs still outstrip capacity. Administrative and service staff are grappling with multiple dilemmas: how to balance the need for increased intervention against whether to serve more families at a less intense rate; the optimal length and intensity for intervention; and what types of intervention are most effective.

- o **Forensic Adolescent Program (FAP)** - The FAP program was originally implemented through grant funding from the state Office of Criminal Justice Planning and was designed to provide juvenile sex offender treatment on an outpatient basis. After the three-year grant funding expired, Ventura County Mental Health incorporated the two FTE positions into the children's mental health program. This program provides specialized, primarily community-based treatment to adolescents on probation for "hands on" sex offenses. There are approximately 30 to 35 clients in the program at a time receiving treatment services, usually for 12 to 18 months. Individual, group, and family therapy are provided on a weekly basis, and the therapy approach has a strong cognitive behavioral and psychoeducational emphasis. The FAP staff also provide evaluations to the court concerning clients' amenability to treatment, risk, and placement needs. Not all of those youth enter the FAP program, although a high percentage do. The mental health staff work closely with the probation officers assigned to the individual youth.

Day Treatment

- o **The Phoenix Program** - The Phoenix School and Phoenix Elementary Program are the joint Mental Health/Special Education day treatment programs in operation in the county. The administrative authority for the

program derives from the Superintendent of Schools and the Director of Mental Health. A record system that meets the regulatory requirements of Special Education and the quality assurance standards of Mental Health has been established. This system has also successfully dealt with the issue of confidentiality. Phoenix School is co-administered by a principal and a mental health supervisor. A child must be identified through the P.L. 94-142 process and have an IEP to qualify for the program. In addition, other classroom and school-based alternatives must be tried before a placement can be made in day treatment. Referrals can emanate from any district in the county. A mental health case manager coordinates placement and available services to meet client needs. A total of 24 children are served at a time.

The Phoenix program, which is based on an adaptive skills acquisition philosophy, is intensive and time-limited to one year. Each class is limited to eight students. Education and mental health staff provide a combined program of special education and treatment designed to meet the individualized goals established for that student in the IEP. Regular team meetings ensure a coordinated approach. Mental Health may provide individual, group, and family therapy, crisis intervention, support, and linkage with other services and agencies in the community. Staff meet with families at least twice a month either at the home or at school. During the summer months an extended school program is also offered.

One of the goals of day treatment is reintegration and transition back to the student's neighborhood school. At six months, Phoenix staff meet with staff in the child's school district to examine the range of options for the student and to work out a transition plan. Three months prior to the year's completion, a youth may "transition" back to his or her school for a partial day, either to a special education or regular class. A resource specialist works with the teacher to provide training and assistance with the reintegration. Mental Health may also stay involved with the youth through the case management and outpatient service modalities.

- o **Enhanced Special Day Class** - These special classrooms on neighborhood school campuses offer special education and mental health services for approximately 72 children who are seriously emotionally disturbed. Interventions for youth in these classes include the services of a psychiatric social worker, a consulting psychiatrist, and case manager; family meetings and agency liaison are also provided. In addition to the special education curriculum, the mental health dimension includes four components: direct therapeutic intervention (i.e. individual, group, and family therapy); consultation to the classroom teacher; collaboration between mental health, special education and regular education staff; and coordination with other agencies. Youth assigned to these classes can participate in school activities and are often mainstreamed into regular classes when appropriate.

- o **VIP Day Care** - The Visions Interagency Program (VIP) is a special school developed by the Corrections Services Agency, Children's Protective Services, county schools, and Mental Health to fill a gap in the continuum of care for high-risk youth. The school operates three days a week and also provides assistance with job training and job hunting. Staff from all four agencies working at VIP are on site and available to both court dependents and wards on a regular basis. These students attend school, have group and individual therapy, and are involved in an independent living skills curriculum as well as a number of recreational and community activities. There are up to 16 students on site, and students generally are in the program for approximately two semesters. Follow-up and ongoing mental health services are provided to students upon graduation. The goal is to help the youth and their families stabilize so that the least restrictive placement can be maintained. The majority of wards at VIP come from the Colston Youth Center, although other youth on probation may also be referred.

Foster Care Homes and Crisis Shelter

The child welfare system includes a range of foster care options for youth in custody or undergoing evaluation. Three types of foster care homes are used in the system: shelter (temporary protective custody), regular foster care for youth in the custody of the state, and enriched foster care. Shomair staff provide a mental health component to this system. In Ventura County, an average of 35 youth are referred into the shelter program per month; 325 are in foster placement; and an average of 28 are in enriched foster homes.

- o **Crisis Intervention Homes** - Emergency shelter care is provided for those youth who have been referred to Protective Services for custody. The focus of the crisis intervention shelter care is on stabilization and assessment. Every child taken into custody is seen by a mental health worker within 72 hours. The foster care parents, mental health worker, and child welfare worker act as a team to provide support, comfort, and counseling to the youth, while at the same time assessing the child and family situation in order to develop recommendations for the custody hearing and for future treatment planning. A shelter foster family may have three to four youth in the home at any one time. The length of stay in shelter care is a maximum of 30 days. For three days every six weeks, respite is provided for the shelter parents.
- o **McAvoy House** - In early 1989, because of a severe shortage of shelter homes to adequately serve the number of children taken into protective custody, a six-bed crisis care home, McAvoy House, was established. This home, jointly funded by Interface and the Ventura County Children's Project, provides a structured therapeutic environment, a setting for observation and evaluation, and respite for children in crisis in their own homes, in enriched foster care, or in group homes.

- o **Enriched Foster Care** - Ventura County's enriched foster care program, also referred to as Shomair, is often called therapeutic foster care in other communities. The Shomair homes are part of the network of foster homes in Ventura's child welfare system, but added support is provided by mental health professionals to the foster parents and child in each home. In tandem with child protective service staff, seven MSW Shomair workers (a supervisor and six therapists), all with child welfare knowledge, work with approximately 25 foster families and the children placed with those families. Each worker has a range of four to ten cases. This staff also provide the evaluation and support to the youth in shelter care and conduct approximately 35 assessments per month. A Shomair worker may be called in to work with a child in regular foster care who is having special difficulty. In these cases, the Shomair worker might provide the extra support a child needs or recommend other treatment options.

In enriched foster care, the social worker's role is "to stick with the child" throughout placement and to provide six months of follow-up care and support when the child returns to his or her family. The Shomair worker visits the foster family and child weekly to provide consultation and support to the foster parents, who are considered to be the child's primary therapists. Staff are also available to families 24 hours a day on an on-call basis. One Shomair staff person has been dedicated to recruitment, orientation, and in-depth training of foster parents. In addition, trainee support groups for foster parents are held. Shomair foster parents receive a higher rate of pay (\$702 per month) than regular foster parents, who receive \$485 a month, to compensate for the more intensive work with the child.

- o **Youth Crisis Services and Cool Homes** - In addition to the other foster care resources, Ventura County has both crisis intervention and emergency shelter care for youth that are neither child welfare dependents nor juvenile court wards. Interface, through joint state and local funding, provides the Youth Crisis and Cool Home Programs as part of the county's safety net for children and families experiencing crisis and requiring alternative emergency shelter services.

Transitional Residential

Short-term, community-based residential care is provided to youth through the major child-serving systems. These transitional residential programs include Colston Youth Center for youth in the custody of the Juvenile Court and Santa Rosa Treatment Home.

- o **Colston Youth Center** is a 45-bed, medium security, residential facility, offering a program that balances issues of treatment and security needs. A telephone screening is conducted with the investigating probation officer, and information regarding the suitability of a youth for Colston is incorporated into the court report. Colston serves youth ages 13 to 17 who have a lengthy delinquency history as well as a number of mental health

problems, family problems, child abuse, substance abuse, depression, and/or anxiety disorders. Youth are committed to Colston for 120-, 150-, or 180-day periods. Each youth is assigned to an interagency treatment team which consists of a social worker, a teacher, corrections services officers, a psychologist, and a probation officer. The psychologist and the probation officer serve on all three treatment teams. Each team has primary responsibility for developing and implementing each youth's individualized treatment plan. Twice-a-week meetings of the treatment team help to ensure a team consensus decision-making procedure.

The treatment approach is eclectic, and includes behavior modification via a point and level system, group and family therapy, some individualized therapy, peer counseling, and a positive peer culture environment. Colston staff feel it is essential to have families involved, and every other week, families participate in family therapy sessions either individually or in a multifamily group. A high percentage of youth in the program have substance abuse problems; while no substance abuse treatment services are provided, members from Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous come in weekly offering three support groups for residents. Residents may also gain access to outside support groups during their Colston stay. The general issues that all interagency staff at Colston emphasize with the residents are skill building, particularly in effective communication skills, victim awareness, empathy building, community service, anger management, peer pressure, impulse control, and responsibility and accountability for their actions. The county's Juvenile Court judge views Colston as a "transformed juvenile correction facility," a preferred alternative to committing youth to the California Youth Authority and a way to involve families.

One full-time staff member is responsible for most of the aftercare for Colston residents. Six weeks prior to a youth's release, an aftercare meeting is held to develop a plan for the youth's post-release care. The aftercare mental health staff work with the youth, the family, the school, and probation officer to ensure that the plan is carried out. If not assigned to the aftercare case manager, youth and their families may return to Colston to continue services with the Colston social worker or may be referred to the Options Program or other private therapists in the community. Youth might also transition to the VIP program to receive mental health services there.

- o **The Santa Rosa Treatment Home**, operated by Parents and Friends of Mentally Ill Children (PAFMIC) under contract with the Mental Health Department, is a four-bed intensive treatment, socialization, and rehabilitation transitional residential group home serving four severely emotionally disturbed youth, ages 6 to 18. Using a parent-teaching model, the primary goals of the program are to provide a placement alternative to admission to the state hospital; provide a transitional program for youth exiting the state hospital, private psychiatric hospitals, and other more restrictive residential treatment programs; pursue family reunification

whenever possible by involving family members in family therapy; provide ongoing family-oriented treatment planning, socialization, and rehabilitative activities; and discharge clients to a lesser level of care (foster home, family or relatives). The home is staffed by two full-time live-in parents, a one-half time social worker, and a six-hour-per-week child psychiatrist. The children placed in the home attend public school (regular education, special education or the Department's day treatment/special education program) and spend every other week with their biological family.

Long-term Residential

Long-term residential care is provided in group homes that are funded through Aid for Families with Dependent Children-Foster Care (AFDC-FC). These homes are located both in and out of the county. In California, there is tremendous concern about the alarming cost of group home placements. According to a recently published report, Ten Reasons to Invest in the Families of California, in 1988-89, 11,100 youth were in group home placements in California, costing a total of \$728 million or an annual cost per child of \$31,000. Group home facilities vary considerably from those that are relatively small in size (4 to 10 beds) to those with over 100 beds. A group home facility is defined by the Department of Social Services as "a nonsecure, privately operated residential home of any capacity, including a private child care institution, that provides services in a group setting to children in need of care and supervision, and which is licensed as a community care facility by the department". Through Fiscal Year 1990, group homes were classified according to four models:

- o Family - These homes are primarily designed to provide socialization for children who do not display age-appropriate social and relationship skills. Little or no psychiatric or psychological services are provided.
- o Psychiatric - These group homes are primarily designed to treat children with diagnosed psychiatric problems. Full-time staff provide direct psychiatric services to all children in the facility.
- o Psychological - These are intended to treat underlying emotional and psychological problems of children and families and to address behavioral issues. Part-time staff provide direct psychological services to children.
- o Social - These homes treat children exhibiting social/behavioral problems who do not evidence marked emotional problems. Part-time staff provide direct psychological services to some children in the home.

According to the report cited above, statewide, approximately 70 percent of the youth in group homes are placed because of parental neglect, incapacity, or absence. The remainder are placed because of sexual or physical abuse. In 1987, 70 percent of children placed in group homes resided in the homes categorized as either psychiatric or psychological; but according to estimates, only 10 percent of

all children in group homes in California actually received services from local departments of mental health.

Inpatient Care (Acute and Long-term)

Inpatient care is seen as a last resort placement. The Ventura system is designed to provide a range of less restrictive options and has no adequate acute psychiatric hospital for children and adolescents. When acute hospitalization is needed for children, they must be placed in an adult inpatient unit with one-to-one supervision or into two contracted beds at private psychiatric hospitals. These beds and their availability are managed by one of the children's services supervisors. For long-term placements, Ventura has placement slots (6 beds) at Camarillo State Hospital.

Specialized Services

The purpose of the Community-Based Residential Alternatives (CBRA) program is to provide seriously emotionally disturbed youth and their families with flexible dollars or staff resources for wraparound services that will enable youth to remain in their communities and attend school. A case manager is integral to program planning and coordinates the flexible services. Support services can include: respite care, enhanced supervision, behavior specialists, recreational therapy, a special friend, and peer support. If, for example, it is determined that a child in a therapeutic foster home requires greater supervision than is presently being provided, CBRA provides the mechanism for obtaining the additional funding needed for the supervision, thereby maintaining the child in the setting. Were this mechanism not available, the child might be moved to a more restrictive and expensive setting.

VII. SYSTEM LEVEL COORDINATION MECHANISMS

Background

Formal and informal mechanisms for coordination and collaboration exist at the policy, service planning, treatment, and case planning levels. This commitment to collaboration originated with top leadership, but mechanisms currently are in place at multiple levels. The structures for planning and problem resolution that have been created, and the trust that eventually has developed from working together, have been critical elements to the system's effectiveness and continuation. The Ventura Children's Project began as a collaborative effort emanating from a member the Board of Supervisors, a juvenile judge, and the Director of Child Mental Health making a commitment to improve services to the most disturbed children in the county. The member of the Board of Supervisors, an elected official, had the sanction and the clout to pull together the executives of the key child-serving agencies for regular meetings. These meetings, which began as brown bag lunches in the office of the Supervisor, launched the

formation of the Interagency Juvenile Justice Council and the Interagency Case Management Council.

System Level Coordination

- o **Interagency Juvenile Justice Council** - This Council is the policy-making body of the Ventura County children's system. Its chair is the presiding judge of the Juvenile Court, and its members represent the highest level of public leadership in the county dealing with children and their families. The members include: the County Counselor, Public Defender, District Attorney, Sheriff, Chief Administrative Officer of the Juvenile Court, Director of Probation, member of the Board of Supervisors, Superintendent of Schools, and Directors of Child Welfare and Mental Health. No substitutes can serve on the Council or be sent to meetings. The Council has been meeting regularly since 1984; in the beginning, meetings were held monthly.

Over the years, the focus of the Council has evolved. Early on, the emphasis was on learning about each other's agencies and issues, building trust, and developing a system mentality. Through that process, problems and service gaps were identified. At this level, decisions could be made and resources committed to address both agency and systemic issues. Currently, the Council still serves as a vehicle for identifying problems, developing interagency solutions, and working through agency conflicts. Decision making is based on a foundation of trust and joint ownership. The Council reviews all agency budgets and provides unified support to the county's youth programs. Council involvement is on both a state and local level -- interceding in state legislative and administrative issues as well as planning and service delivery issues within the community. For example, the Juvenile Justice Council played a role in advocating to maintain the state funding formulas for foster homes, in shortening the calendar for juvenile court processing, and in creating the Resource Development Project to involve the private sector and expand the resources available to county youth and families. The success of the Council can be attributed to a number of factors: the involvement of both elected officials and agency directors; leadership committed to making the process work; the policy prohibiting the sending of delegates; and consistent and regular meetings. As a result, the Council has the sanction and leverage it needs to be effective.

- o **Children's Commission** - A countywide Children's Commission is currently under development. The Commission, which expands the interagency focus beyond the targeted populations to all children in the county, will provide a forum for involving public and private agencies at the county and city level.
- o **Interagency Case Management Council** - The Interagency Case Management Council was created to enable interagency planning for those cases that are especially difficult, i.e., where there may be a lack of

appropriate resources in the community or the youth may fall between the jurisdictional cracks of different agencies. The Council provides a forum for interagency representatives to engage in problem solving around a case. Initially, the Council met every two weeks. Currently, meetings are less frequent because of improved communications between the agencies and the availability of a wider array of services; if necessary, the Council can be convened in emergency situations. The agency representatives on the Council are middle managers who have the authority to commit resources for their agency, a critical factor in the ability of the Council to function effectively. The Council membership also includes the Coordinator of Case Management. At meetings, different cases are presented, and, additionally, there may be follow-up to previously presented cases. Issues might include discussion of service options for an especially troubled youth, resolution regarding which agency should have fiscal responsibility for services to a child, mediation of conflicts over agencies' legal mandates for a child, and review of cases for out-of-county and out-of-state placements. All members of the Council are active in case planning and problem resolution. Every six months, the Interagency Case Management Council reports to the Juvenile Justice Council to identify system problems that must be addressed.

- o **Agency Screening and Placement Committees** - Within Child Welfare and Juvenile Justice, there are interagency processes designed to review cases and treatment plans. This review is a prerequisite for more intensive placement changes.

The Placement Screening Committee within Children's Protective Services includes Shomair staff, senior staff of CPS, group home specialists, and other key agency representatives in the child's life. The committee reviews difficult cases to determine appropriate placements. Any youth in the custody of CPS who are being considered for Shomair enriched foster care, case management, a group home, or any more restrictive service placement must be reviewed by this committee. This review is mandatory. In California, legislation (SB 14) requires that children who are dependents of the state be served in the community if at all possible; the Children's Protective Services Agency is appointed as the guardian ad litem to implement each child's service plan.

Juvenile Justice's screening process reviews children who are pending court adjudication and provides recommendations to the Juvenile Court judge for final disposition. Mental health staff, the school principal for the court, and the probation officer participate in the process.

Joint Services and Joint Evaluation

As noted, Ventura County has a range of services that are administered, funded, and delivered jointly by multiple agencies. These include, among others, the services at Colston Youth Center, the Shomair team's involvement in Children's Protective Services providing crisis intervention and enriched foster care, the

Phoenix School day treatment programs, and the enhanced special day classes. Additionally, the Ventura sub-systems collaborate in cross-system data collection and evaluation. Joint evaluation activities are discussed in greater detail in a subsequent section.

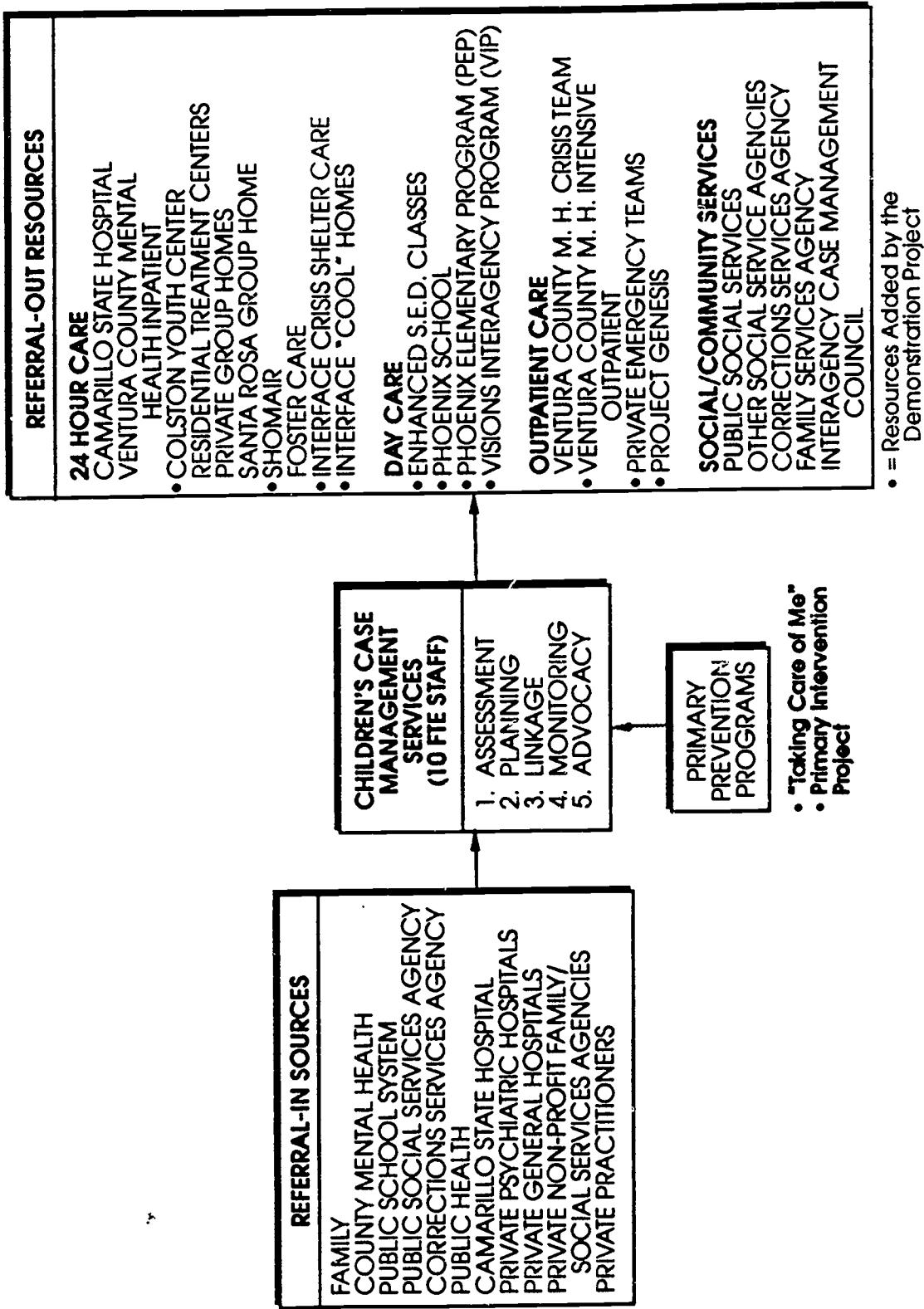
VIII. CLIENT LEVEL COORDINATION MECHANISMS

In the early 1980s, case management was one of the first activities provided by the Ventura Mental Health Department to reduce and further prevent state hospital placement of adolescents. Currently, case management is provided by Mental Health to youth in each of the major public child-serving agencies that are part of the Ventura system, as shown on the chart on the following page. While other service components of the Ventura Children's Project (such as Shomair, Colston and Phoenix) may only serve youth designated as the legal responsibility of a particular agency, the children's case managers cut across all agencies. However, not all youth in the Ventura system have a case manager. The target population for case management services includes all child welfare youth who are receiving any service considered to be above the level of foster care (for example, enriched foster care or group homes); youth in the juvenile justice system who are group home candidates or have recently been discharged from Colston; youth in special education who have been referred to day treatment or an out-of-home placement; or other at-risk youth in outpatient intensive care, Genesis, crisis shelter care, the Santa Rosa Treatment Home, group homes, private psychiatric hospitals, or Camarillo State Hospital. Referrals can come from any agency.

Court dependents and wards being considered for placement are evaluated by the respective screening and placement committees of Children's Protective Services or Probation. These committees assess the child's needs and make recommendations for services and/or placement. Case Management is an integral partner in this process. For school referrals for assessment for day treatment or out-of-home placement, the case manager by law becomes a member of the expanded IEP team. Every child placed is assigned both a case manager and a worker from Special Education, Children's Protective Services, or Probation. Staff of the latter two agencies must be involved if they have legal custody of the youth. Interagency agreements delineate both the separate and shared responsibilities of each of these staff. While there are some overlapping responsibilities, according to Ventura staff, duplication of services is not a problem for the following reasons: "First, the case manager brings special expertise in mental health assessment, treatment, and resources. Second, since these children and families often pose extremely difficult and multifaceted problems, having two professionals collaborate can be extremely helpful to clients and staff."

The case management staff consists of a coordinator, eight MSWs, and two RNs. An average caseload is 1:25, which some case managers believe is too high. This ratio includes those cases that are active as well as those for which the case manager is primarily providing follow-up services.

Case Management Sub-System



• = Resources Added by the Demonstration Project

Flow charts developed by Dr Daniel Jordan, Systems Evaluation, Ventura County Mental Health.

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Effective December 1, 1991, the children's case management team was reorganized into three distinct, specialized subteams in order to provide better services to the youth in the team's caseload and to maximize interagency coordination and collaboration with regard to the development and implementation of the interagency service plan for each client. Historically, each children's case manager had a mixed caseload comprised of children and adolescents at risk for, or already in out-of-home placement, as a result of serious emotional disturbance and/or of court ordered placements by the dependency court (Child Welfare), the Juvenile Court, or the IEP team of a local school district. However, as caseloads continued to rise, it became essential that each of the case managers be knowledgeable about the complex regulations, policies, and procedures of the other agencies involved with the youngsters. It became increasingly apparent that the needs of the children and their families, as well as the needs of the other agencies, would be better served by developing small, specialized, "expert" teams, housed together, who would have a specialized caseload of only child welfare, juvenile court, and special education cases. In addition to promoting the development and maintenance of specialized knowledge and expertise internally, the agencies would benefit by having a small, knowledgeable mini-team of case managers to work with collaboratively. Joint staff meetings have begun involving these specialized case management teams and staff of the respective agencies.

The case management model in Ventura includes assessment, planning, linkage, brokering, monitoring, and advocacy. The provision of direct clinical service is not part of the case manager's role except in those rare cases where the case manager is the only care provider involved. The case manager is responsible for coordinating all the services and providers involved in a youth's life. The case manager's relationship to and role vis a vis other agency staff, as mentioned above, is delineated in the interagency agreements negotiated between Mental Health and the major child-serving systems. The case manager develops a plan, which is updated every six months, with other appropriate agency staff and the family. Case management services are reimbursed through Medicaid.

The case manager meets with the youth and the primary therapist at least monthly, sometimes bimonthly, and has regular contact with other agency personnel involved with the youth and family. An informal, on-call, backup arrangement enables the case manager to be available when needed in a crisis situation. The case manager is "the constant" in the child's and family's life -- staying with the youth as long as that youth is in the system.

One of the paramount goals of the case management team is to keep the child in the least restrictive setting. In the Ventura system, this goal is expected to achieve two outcomes: to benefit the child and family and to control the resources spent on deep-end placements. Case Management does play a gatekeeping role in reviewing the appropriateness of moving a child to a "more restrictive" level of service. Case Management also monitors "the big picture" by tracking the number of youth in various placements and some of the more intensive service

modalities. The unit maintains a data base on placements and costs, and issues monthly reports providing this information.

In addition to the weekly, client-centered, interagency staff meetings of which the specialized case management teams are a part, the entire 10-member case management team meets monthly for three hours for in-service training and to review and discuss problem cases, new policies and procedures, and systemwide statistical information.

According to the Coordinator of Case Management, in order to be effective, case managers must have experience and credibility in a range of settings; strong clinical skills, particularly in crisis intervention; a sense of humor; and good interpersonal skills. In Ventura, the salary range for case managers is \$29,000 to \$39,200.

IX. SYSTEM OF CARE ACTIVITIES

Family Involvement

The philosophy of the Ventura system of care is grounded in working to keep children at home with their families if at all possible. One of the stated "five essential characteristics" of the Ventura system is the development of services committed to family preservation and reunification. The Ventura system is also driven by a legislative mandate that states, "Clients and families should directly participate in making decisions about services and resources that affect their lives." The service system is designed, therefore, to support this concept of family- and child-centered care. Home-based services, case management, and the other community-based programs are intended to work with and support families. Additionally, all of Ventura County's treatment requires parental approval in writing of both the assessment results and the actual treatment plan's goals and objectives. Parents can appeal if differences between them and a therapist cannot be resolved.

Each of the sub-systems within the Ventura system has developed mechanisms for involving families in planning, treatment and parent support. In all the sub-systems, staff will make home visits. In Special Education, families are involved in the IEP process and with any of the special programs serving the youth. For example, in the Phoenix Day School, staff meet with the student's family twice a month, either at the school or in the home. Parents provide the school with a daily report of the child's functioning at home.

In the juvenile justice system, when the youth is screened, the judge determines the involvement of the family. For youth in Colston, approximately 80 percent of the families participate in a variety of activities. Families are provided with an orientation when youth enter the program. Typically, parents and the youth participate in joint treatment sessions; the focus of treatment is often in reconciling family issues. In some cases, individualized treatment for a family

member is provided. There are also multifamily groups involving approximately six families meeting weekly. Evening hours are available to accommodate the needs of parents.

In the child welfare system, contact is encouraged between the natural and foster parents. Shomair staff work closely with all parties and facilitate the involvement of parents. Reunification with natural families is the goal. If that is not appropriate, Shomair staff help to facilitate permanency planning and placement for the child.

Cultural Competence

Ventura is committed to developing a service system that is responsive to and respectful of different cultural groups in the community. While Ventura County is predominantly white, it does have a culturally diverse population -- 65.9 percent Caucasian, 26.5 percent Latino, 4.9 percent Asian American, 2.2 percent African American, and 0.5 percent Native American. In three of Ventura's ten cities, Latinos comprise almost 60 percent of the population. This "minority" population in Ventura County and in the state as a whole is growing, and it is estimated that by the year 2010, 55 percent of California's population will be Latino, Asian, and African American.

The Ventura County Mental Health Department recognized that to better serve this population, the agency and the system would have to undergo major institutional changes. This process does not occur quickly or without resistance, but Ventura is struggling to make these changes and working on multiple fronts to do so. In 1990, the Mental Health Department hired a Minority Services Coordinator to work with administrators and staff to develop and implement a master plan so that the agency and the services it provides to clients would be more culturally competent. The Coordinator brings to this position a wide range of experience in education, community organization, administration, and working with minority populations. This position involves playing a variety of roles including staffing committees, organizing training activities, and involving all levels of the agency in making cultural competence a priority.

In 1991, a cultural competence master plan was developed which addresses four key areas: policy and administration, human resource development, services to clients and families, and research and evaluation. For each of these areas, objectives, activities, resources, staff responsibilities, timelines, and monitoring procedures are delineated.

- o **Policy and Administration** - The objectives in this area include the following:

- Develop a mission statement which includes cultural competence.
- Develop a cultural competence master plan.

Develop and maintain communication with managers and supervisors to implement objectives.

Identify revenues for implementation.

Develop a policy statement and performance expectations for organizations that subcontract with Mental Health.

A number of vehicles have been established and activities undertaken to accomplish these objectives. The Minority Services Coordinator is a member of the management team which meets weekly for four hours to review and approve agency plans. For change to take place, a commitment is needed at the administrative level to incorporate cultural competence in the agency's mission, policies, and procedures.

The Minority Services Coordinator also chairs the Minority Services Staff Committee. This committee is comprised of Department employees from different sections representing a variety of job classifications. A number of subcommittees have been created, although not all are currently active. The subcommittees include:

Recruitment and retention,
Education and training,
Evaluation,
Children (an interagency subcommittee), and
Community relations and outreach.

Of these subcommittees, the outreach committee is the most active. This committee has developed recommendations and strategies for improving outreach that consider the needs and preferences of different cultural groups. The work of this subcommittee will play an important role in implementing some of the objectives in the master plan related to serving clients and families.

Ventura County Mental Health also has established a Minority Advisory Planning Subcommittee of its Mental Health Advisory Board, the body that provides community input to the Department. Those members of the Advisory Board who are members of ethnic minority groups comprise the Minority Advisory Subcommittee. This group has played an active role in the overall reform of the adult system in Ventura.

- o **Human Resource Development and Staff Training** - A number of objectives have been developed to enhance human resource development and staff training as part of the Mental Health Department's cultural competence plan:

Establish interpreter training for mental health staff.

Create a mental health cultural competence resource list.

Develop cultural competence certificate training.

Establish a recruitment coordinator.

Develop a minority staff retention program.

- Conduct orientation and training in cultural competence for current and new staff.
- Develop a mentor program.

To date, the major emphasis in this area has centered on training, which has been designed as a three-tiered process. These levels include an introduction to cultural competence for management, supervisory, and line staff; cultural competence training workshops on specific topics such as family systems, acculturation, the dynamics of difference, and mental illness within specific ethnic and cultural communities; and development of ethnic specialty teams, focusing on the major ethnic groups in Ventura County, that will serve as in-house experts.

In January 1991, an initial four-day educational program was targeted at program managers and supervisors on what it means to be culturally competent. The management and supervisory staffs each met separately to brainstorm around obstacles to becoming culturally competent and to establish objectives for overcoming these obstacles. A draft of the cultural competence master plan was developed through this meeting. Training sessions have also been conducted for line staff focusing on cultural self-assessment, cross-cultural communication (working with interpreters), and cross-cultural issues in counseling. Future training activities will include a program for the interagency staff involved with children's services and an orientation for all new employees. An introductory cultural competence handbook has also been developed. In addition to these in-house activities, Ventura County has a grant with the state to provide cultural competence training to three other counties. The objective is to assist these three counties in developing their own cultural competence master plans.

Other strategies in the recruitment and training area include the following:

- An educational incentive training program (\$24,000 annual budget);
- Job announcements seeking applicants who are bilingual and have experience working in multicultural settings; and
- Differential pay for staff with bilingual skills.

Efforts under development include:

- Establishing liaison with schools of social work and other relevant educational programs to recruit new graduates (eight of 20 students in the Ventura County University of Southern California MSW program are ethnic minorities);
- Developing internships for trainees in the various disciplines;
- Identifying mentors to guide new staff; and
- Involving staff in intensive language development programs.

- o **Services for Clients and Families** - The priority in this area has been on improving outreach and informing the public about mental health services and how to access them. Different strategies for outreach and for ensuring that services are more culturally competent have been developed for the adult and child populations served by the Department.
- o **Research and Evaluation** - Efforts in this area mainly focus on developing a client data base with information on client ethnicity, diagnosis by ethnicity, years in the United States, and bilingual status. In addition, ethnicity of staff across divisions and classifications is tracked and monitored. The Department's Chief of Systems Evaluation is currently developing methods to examine differential outcomes across ethnic groups. Questions to be addressed include, for example: Are children of different ethnic backgrounds admitted to other agencies in less than an equitable distribution? Are there differential outcomes within each of the agencies across ethnic categories? Are different amounts of service given children according to their ethnicity? Do the resulting outcomes vary by ethnic category? Methods are being developed to compare ethnic category of staff with those of the clients. The Chief of Systems Evaluation and the Minority Service Coordinator are also jointly developing a methodology for assessing an agency's level of cultural competence and for planning how to improve cultural performance, based on a synthesis of the Ventura Planning Model's five key areas and the principles of cultural competence.

Advocacy

Advocacy is an important strategy used by Ventura to focus attention on the target population and on system development. Ventura has effectively used a multifaceted approach to advocacy. Parent groups, the Department's Advisory Board, and all the interagency mechanisms play a role in advocacy. The Juvenile Justice Council, because of its composition of agency directors, a member of the Board of Supervisors, and judges, is actively involved in advocating at the state level for adequate funding and state support of program activities.

Because the Ventura system was originally implemented as a demonstration project, administrative staff, key officials, and community leaders have been highly visible at the state level in advocating for a continued commitment to this approach for serving children with mental disorders. Data documenting cost and client outcome information have been a critical tool in this advocacy strategy. The expansion of the Ventura concept to other counties in the state and to the adult service delivery system is a measure of the success of the Ventura children's mental health advocacy effort. Continued funding support, despite major deficits in the California budget, represent another benchmark of success.

X. FINANCING

Ventura County's system of care began with a two-year demonstration grant of \$1.5 million in state funds to develop and test the costs and benefits of a comprehensive system for the delivery of mental health services to children, youth, and their families. These funds were added to existing Mental Health Department funds, and the total amount was then used to reorganize services into a comprehensive system of care.

In addition, all Ventura County system of care programs that involve another agency are jointly funded and staffed. The county has leveraged dollars from other agencies using mental health dollars as an incentive to develop programs for common target populations, including emotionally disturbed court wards and dependents, severely emotionally disturbed children in Special Education, and abused and neglected children in Social Services. These jointly-funded programs provide community-based treatment alternatives to state hospital and group home placements. The assumption is that funds expended for state hospital beds and out-of-county placement in group homes are put to better use when spent for community-based services designed to keep the child in school, in the home or in foster care.

The Colston Intensive Residential Program serves as an example of a jointly-funded, interagency program. This 45-bed intensive treatment program for youth adjudicated through the juvenile justice system is a local alternative to out-of-county placement. The total program budget is \$1,101,500 supported by funds from several agencies:

- \$550,000 from Corrections Services,
- \$225,000 from the County Schools (\$100,000 from existing funds and \$125,000 from reallocated local funds),
- \$326,500 from Mental Health.

Financing for the Ventura County system of care is complex, involving multiple agencies and funding sources. In Fiscal Year 1991-92, mental health expenditures for children's services programs exceeded \$5.7 million. The 1991-92 Children's Service Program & Fiscal Overview, shown on the following page, provides a detailed summary of how these dollars are allocated to services, the number of full-time equivalent staff or beds, the number of clients served, and the source of revenue. Serving a target population of approximately 1,900 children and adolescents, Ventura County Mental Health spends slightly more than \$3,000 per child per year.

A breakdown is not available of the amount of dollars every agency that is part of the Ventura system spends on services to children and adolescents who are seriously emotionally disturbed. However, the chart on page 44 provides the total 1990-91 operating expenses for the major agencies in the Ventura County system of care.

1991-92
CHILDREN'S SERVICE PROGRAM & FISCAL OVERVIEW
Ventura County Mental Health

Model/Program Name	Location	Tax Grant	Medical	Revenue *	UMDAP	Other Agency	FTE/Beds	Clients Served	MH Funds	Comments
Prevention										
1. Primary Intervention Project	3 School Dist.	x				Ed.	3 FTE	N.A.	\$22,000	Renewable grant from State MH Dept.
2. Student Supp. Servs Project	County Sch. Dist.	x				Ed.	.5 FTE	N.A.	\$21,522	Social-emotional curriculum development
Emergency										
1. Juvenile Hall Screening	Juvenile Hall	x			CSA	1.6 FTE	205	\$45,900	Primary focus is suicide prevention	
2. Shelter Care Screening	Foster homes	x			PSSA	1 FTE	350	\$36,817	Contract	
3. Genesis In-home Intervention	Client's Residence	x			Interface	4 FTE	50	\$165,600	Primary contacts with adults in crisis	
4. Central Crisis Team	Ventura MH	x	x	x		.5 FTE	100	\$20,000		
Outpatient										
1. Outpatient	Clinic & Outreach	x	x	x	Ed.	11.5 FTE	300	\$960,600		
2. Enriched SED Classes (8)	School Sites	x			Ed.	5 FTE	160	\$271,000	AB 3632 funds, 5 school sites	
3. Forensic Adolescent Program	Ventura	x	x	x	Ed.	2 FTE	25	\$150,000		
Day Treatment										
1. Phoenix School	School Site	x	x	x	Ed.	4.5 FTE	18	\$292,100	16 day treatment slots, Special Ed.	
2. Phoenix Elementary Program	School Site	x	x	x	Ed.	2 FTE	10	\$70,000	8 day treatment slots, Special Ed.	
3. Visions Interagency Program	School Site	x	x	x	Ed.	2 FTE	10	\$84,800	24 day treatment slots, Regular Ed. (new)	
Case Management										
1. Case Management	County-wide	x	x	x		10.2 FTE	320	\$1,072,300	Broker services for system	
Crisis Residential										
1. Interface Crisis Res. Home	Oxnard	x			PSSA, Interface	6 Beds	5	\$87,310	Contract	
Transitional Residential										
1. Enriched Foster Care (15)	County-wide	x	x	x	PSSA	20 Beds	28	\$240,000	6.2 FTE	
2. Colson Intensive Interv. Prog.	Co. Detention Ctr.	x			CSA, Ed.	45 Beds	125	\$326,500	Added 6 FTE to create resi. treatment program	
4. Santa Rosa Treatment Home	Camarillo	x		x	PSSA	4 Beds	10	\$114,700	Contract	
5. Private Placements	Group Homes				PSSA, CSA, Ed.	85 Beds	100	\$249,211	AFDC-FC funded, small MH patch	
Acute Hospital										
1. County Inpatient Unit	Ventura MH	x	x	x		2 Beds	4	\$270,100	Gross cost at \$370 per day	
2. Vista Del Mar Hosp. (Private)	Ventura					4 Beds	30	\$13,500	MD Contract	
State Hospital										
1. Camarillo State Hospital	Camarillo					5 Beds	10	\$473,405	Gross cost at \$259.40 per day	
Evaluation										
Administration						1.5 FTE		\$125,000	Includes computer support services	
County Overhead						2 FTE		\$96,700	Agency & County support	
Total FTE						51.3 FTE		\$521,916		
Local Beds Community Based Beds						71 Beds				
Group Home & Hospital Based Beds						100 Beds	1860		Ventura County Mental Health Cost Summary:	
Total Beds/Clients Served						171 Beds			Pop= 689,000 (31.8% under 18 = \$26.12 per child)	
Total MH Funds									Target Population = 1,900 = \$3,013 per child per year	

*UMDAP - Unified Method of Determining Ability to Pay (client fees)

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Total FY 90-91 Operating Expenses for Ventura County System of Care Agencies

Public Social Services Agency		
AFDC-FC residential care	\$5,999,196	
SED residential care	\$726,094	
Adoptions assistance	\$1,600,000	
Staff operations	\$6,500,000	
Total	\$14,825,290	
County Schools: Special Education		
Total (includes costs for SED and other exceptional students enrolled in special day class only)	\$65,832,303	
Corrections Services Agency		
Total (includes salaries, benefits, and all program costs)	\$14,162,700	
Interface Children and Family Services		
Total (includes shelter care, intensive in-home services, children's resource program and all other child and adult services)	\$1,944,000	
Mental Health Services		
Total	\$5,723,981	
Total Expenditures for System of Care in Ventura County		\$102,488,274

Source: Ventura County Mental Health Services

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Total third party revenues for Ventura County mental health children's services are shown in the Annualized Third Party Revenue for FY 1991-92, displayed on page 46. The revenue for children's programs has increased significantly in the last year because of the growing number of programs that are eligible for MediCal reimbursement. The day treatment programs have applied for MediCal certification and are expected to further increase revenue during fiscal year 1992-93.

As noted, in 1992, California initiated a policy called realignment which transfers resources for health, social services, mental health, alcohol and drug abuse from the general state fund to a local trust fund. This funding mechanism is expected to provide counties with a greater degree of budget control and stability. Based on a formula, counties will receive funds generated from vehicle registration fees and from sales tax revenues. These funds can be used as local match for federal funds.

Recently, Ventura County's public agencies have formed a consortium to develop interagency fiscal strategies to maximize federal resources through more effective use of existing state and county dollars. Managers and fiscal agents from Mental Health, Social Services, Corrections, the schools, and the county administrative office participate in the consortium. Ventura has also been selected by a consortium of private foundations as a site for creating interagency strategies for increasing federal financial participation.

XI. EVALUATION

The legislation establishing the Ventura County Demonstration Project and AB 377, the enabling legislation to continue Ventura's model system and expand it to three replication sites, called for an evaluation of system results that will demonstrate achievement of benefits in terms of treatment goals and cost avoidance outcomes. The evaluation standards in AB 377 were negotiated between Ventura staff and legislative staff. As a result of this legislative mandate, Ventura is one of the few local systems of care in the country that has collected systemwide data and tracked costs and outcomes. The emphasis of the Ventura evaluation is not based on individual service components or individual client outcomes but rather on aggregated systemic changes.

The mental health agency is responsible for collecting data from each agency and maintaining a centralized data base. Youth are grouped and tracked according to the target population in each sub-system such as youth in Juvenile Justice or in Special Education. Systemwide data are collected on a monthly basis on the number of youth receiving a particular service and/or in placement. Follow-up data tracking target population youth over time are also collected. While it is possible within the Ventura data collection and tracking system to track an individual youth's experience across agencies, this is not done primarily because of cost and time constraints. The focus is on systemwide indicators of success: costs to the public sector, recidivism of juvenile offenders, public school

Annualized Third Party Revenue Recap for FY 1991-92
 (Based on revenues collected through April, 1992)
 Ventura County Mental Health

SITE	Fees Collected	Insurance Collected	Medi-Cal Collected	Total Collected
Ventura	\$3,397	\$856	\$265,285	\$269,538
Oxnard	\$2,297	\$7,872	\$193,994	\$204,163
Simi	\$1,361	\$2,447	\$50,544	\$54,352
T.O.	\$3,464	\$0	\$62,110	\$65,574
S. Paula	\$773	\$1,008	\$41,714	\$43,495
Shomair	\$0	\$0	\$190,057	\$190,057
FAP	\$0	\$0	\$23,513	\$23,513
Interface	\$0	\$0	\$9,240	\$9,240
TOTAL	\$11,292	\$12,182	\$836,458	\$859,932

attendance and performance, and youth remaining in their homes and local community. These data and findings are an important internal management tool used for programmatic decision making and for justifying the reallocation of resources. The data have also been essential to the political survival of the Ventura system of care.

AB 377 requires that, in Ventura and the other three replication sites, the total estimated "cost avoidance" in five categories exceeds 50 percent of the demonstration project costs. The five categories specified are: 1) group home costs paid by Aid to Families with Dependent Children - Foster Care (AFDC-FC); 2) children and adolescent state hospital programs; 3) nonpublic school residential placement costs; 4) juvenile justice reincarcerations; and 5) other short- and long-term savings in public funds resulting from the Demonstration Project. These cost avoidance figures are based on estimates of what the county would have spent if youth were placed in these various out-of-home, out-of-county, restrictive placements. Thus, through the use of such alternatives as home-based treatment, day treatment, case management, and therapeutic foster care, the cost of more expensive placements were "avoided". Cost avoidance estimates are also based on reductions in utilization of certain placements and services. Utilization figures are monitored over time and are compared with state utilization data.

The original goal of this project was to reduce the level of expenditure in each category of expense. Now that the system has become fairly stable, the goal has shifted to maintenance of lower expenditure levels. This is a complicated task, since efforts to maintain reduced costs compete with a burgeoning population and inflationary pressures that drive up expenses such as group home costs. A new evaluation report by Jordan and Ichinose, to be published in 1992, describes this maintenance evaluation and updates the outcome measures.

Cost avoidance outcomes for the original project, which was intended to reduce costs, are shown on the chart on the following page. The percentages are based on the ratio between the estimated cost avoided and the total project costs.

The Ventura Project met the treatment goals required by AB 377 as summarized in the discussion that follows:

- o **A 47 percent reduction in out-of-county court ordered placements of juvenile justice wards and social service dependents.** The number of out-of-county court ordered placements of those youth in the custody of Juvenile Justice and Social Services actually declined 47 percent, exceeding the 20 percent goal. The monthly average was 77 youth during the first quarter of the project, September 1985, and 41 during the quarter ending June 1980.
- o **A statistically significant reduction in the rate of recidivism of juvenile offenders participating in the Ventura Demonstration Project.** A total of 183 juvenile offenders with a mental disorder have participated in the Colston program. As of September 1987, 81 had been reincarcerated for at

Cost Avoidance Outcomes: AB 377 Required the Total Cost Avoidance to Exceed 50 Percent of Project Costs

	<u>Costs Avoided</u>	<u>Percent of Projected Costs (\$1,528,265)</u>
Group home costs paid by Aid to Families with Dependent Children-Foster Care (AFDC-FC).	\$410,775	26.9%
Child and adolescent state hospital programs.	\$415,718	27.2%
Non-public school residential placement costs.	\$109,229	7.2%
Juvenile justice reincarcerations.	\$160,020	10.5%
Other short- and long-term savings in public funds resulting from the Demonstration Project: AB 3632 Placement Cost Avoidance.	\$ 78,130	5.1%
Total Short-& Long-Term Cost Avoidance	\$1,173,872	76.9%

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least one day which, according to Ventura officials, is a reduction of 56 percent. The total number of incarcerations across all offenders was 372 prior to admission to Colston and 178 post discharge, a 52 percent reduction. Finally, the difference in the total days of incarceration decreased from 7,632 to 5,346, a 30 percent decline. All three indices exceed the required 20 percent reduction.

- o **A 68 percent reduction in the rate of state hospitalization of youth from the baseline fiscal year 1980-81 level.** In 1980-81, Ventura had an average daily census (ADC) in the Camarillo State Hospital of 8.9 children and adolescents. During a seven-year period, the ADC has been 2.8 youth, representing a 68 percent reduction. The AB 377 reduction goal is 25 percent. Data from 1985 to 1988 show an increase in the ADC, but project staff believe this is related to the rapid population growth in Ventura County. In 1980, when Ventura's population was 529,000, the ADC was 4.7. By 1988 the population had grown to 637,000; the ADC that year, when corrected for population growth, was 3.9, 56 percent below the 1980-81 baseline.
- o **A 21 percent reduction in out-of-county nonpublic school residential placements of special education pupils.** This reduction exceeds the AB 377 goal of 10 percent.
- o **Forty (85 percent) children at imminent risk of placement who have been served by the intensive in-home crisis treatment program have remained at home at least six months.** This exceeds the goal of keeping at least 50 percent of the children home for six months.
- o **Significant gains in school attendance and academic performance of youth treated at the Phoenix School.** Attendance in the Phoenix School was tracked from January 1986 to June 1988. Out of a possible 6,451 days of attendance, pupils attended 5,710 or 88.5 percent. The students' attendance rate prior to their participation at Phoenix is not available, but 55 percent of the pupils had histories of truancy and nearly all had attendance problems. All pupils entering and leaving the Phoenix School receive an academic evaluation using the Woodcock-Johnson Psycho-Educational Battery. Based on chronological ages, the students should be at an average grade level of 9.6 years at entry to Phoenix. They had actually achieved an average grade equivalent of 6.3 years, 3.3 years behind their peers of a similar age. These youth had been gaining an average of .66 academic years for every actual school year. After one year at Phoenix, these students reached a grade equivalent of 7.9 academic years, a gain of 1.6 academic years and a 242 percent increase in the rate of academic progress over the students' previous gain per calendar year.

Project staff also believe that a case can be made for long-term cost savings and benefits if youth can stay out of the welfare, criminal justice, or psychiatric hospital systems and become productive members of society. Stabilizing and

maintaining youth in their community provide hope for the future lives of these vulnerable youth.

Research is being conducted on the Ventura County Project and the three replication sites -- San Mateo, Santa Cruz, and Riverside Counties -- by the Institute for Mental Health Services Research and the Department of Psychiatry at the University of California, San Francisco (UCSF). Three interrelated child services research projects studying multiple dimensions of the implementation of California's model system of care are underway. These research projects represent a collaborative effort between public agencies and an academic institution and are funded by federal, state, and private foundation resources. The California Department of Mental Health is funding a five-year study, known as the California AB 377 Evaluation Project, which since 1989 has been collecting and analyzing data from the four sites. The National Institute of Mental Health is also funding the UCSF Institute to conduct a longitudinal study of clinical incidence and prevalence of mental disorder, service utilization, and cost outcomes within two of the AB 377 counties, San Mateo and Santa Cruz, comparing findings with a control county, San Francisco. The third study involves an evaluation of the Family Mosaic Program in San Francisco, one of the sites of the Robert Wood Johnson Foundation, Mental Health Services Program for Youth.

The project goals for the AB 377 evaluation include assisting the California Department of Mental Health in the establishment of performance criteria, assisting the counties in data collection efforts, monitoring program performance, and collecting and integrating data from multiple state and county sources. Data collected and analyzed come from secondary sources provided by county and state agencies. Although individual client data are included in these data sets, no individual data are directly collected by the research team. According to UCSF researchers, the available data sets contain excellent cost and service utilization variables but include only the most basic individual outcome data. In response to the legislative mandate, the AB 377 Evaluation Project collects data on four system of care performance criteria: ensuring that the target population is being served as intended; reducing the reliance on restrictive levels of care especially state hospitals and group homes; reducing the likelihood of rearrests for youth in the target population in the juvenile justice system; and, improving educational performance of the target population in school settings.

In the Ventura Mental Health Department, efforts are underway to develop a client outcome evaluation system. An instrument called the "Personal Profile" has been developed as part of Ventura's state-funded adult and seniors demonstration project. Evaluation staff have designed a computerized data system measuring basic areas of a client's life. The concept of this approach is being expanded to the children's service system. Once in place, the children's "Personal Profile" will provide ongoing, trend information in such areas as living arrangements, school performance, and health status.

Data and findings from these multifaceted studies should provide valuable information on a number of significant dimensions related to the system of care

approach. Few other states and communities have put as many of the critical elements together to undertake such a systematic evaluation -- the collaboration between the public and academic sectors, the expertise of the research staff, the systemic measures, the data collection mechanisms, the cross-systems collaboration, and the funding support for such research.

XII. MAJOR STRENGTHS AND CHALLENGES

Major Strengths

The Ventura project has served as a leader and forerunner for the development of local systems of care for children and adolescents who are severely emotionally disturbed. When many national experts in the children's services field were merely talking about the need for a new approach to serving troubled children and families in this country -- an approach that would involve interagency coordination and collaboration, a comprehensive array of services, and community-based care -- Ventura was working to operationalize these concepts. The country has learned a great deal from the Ventura experience. A number of initiatives, including CASSP and the Robert Wood Johnson Foundation's Mental Health Services Program for Youth, have looked to Ventura for guidance in the development of local systems of care. States and communities across the country have studied the Ventura Planning Model in their own efforts to develop systems that are appropriate to their environments.

The Ventura experience is not only about creating a system of care; it is about creating systems change. Ventura staff have tremendous knowledge about what it takes to change systems and to implement a system of care. They have had over eight years of experience in building trust, testing assumptions, and restructuring institutions. They have been successful, because the strengths Ventura has developed dovetail well with the crucial elements necessary for systems change. These critical elements include the following:

- o **Leadership** - The importance of leadership cannot be underestimated. Ventura has demonstrated an understanding of the value of obtaining and fostering multiple sources of leadership to develop a power base of support. Much of the credit for Ventura's success is due to the vision, leadership, and skill of the current Director of the Ventura Mental Health Department, who has been involved with Ventura Mental Health since the early 1980s. However, he could not have been successful in creating systems change without strong support from other key leaders -- in Ventura County, this meant the Board of Supervisors and the judges. Individuals from both these arenas were willing to take risks and bring others together to explore ways to serve youth differently. Leadership and support at the state level, in the legislature and the California Department of Mental Health, were also essential to make the necessary legislative and administrative changes to enable the state and county to move in new directions.

In addition to leadership at the top levels, strong leadership at the agency level is also critical to implementing a good idea. Ventura has worked to encourage and sustain leadership at this level as well. When the former Director of the Children's Demonstration Project took over the director's position of the Mental Health Department, a key staff member, who had been involved in the early stages of Ventura's development, assumed the leadership of the children's system, continuing to provide able direction and continuity in carrying out the mission. Other agency staff in management positions have also provided stability, competent leadership, and vision.

- o **Vision and Clarity of Goals** - The Ventura project has had a strong philosophical underpinning and vision from the outset. The message is clearly stated; it is consistent; and it makes sense. The core value for Ventura is that a community-based, interagency system of mental health care which targets the most disturbed children will provide the greatest benefit to children, their families, and the community at the lowest cost to the public sector. This mission statement and the essential elements of the Ventura model drive all the activities of the system and, over time, have permeated all levels. While there have been some pressures to broaden the population or focus less on costs, Ventura has remained steadfast to its goals.
- o **Planning** - The leaders of Ventura understand planning and are highly skilled strategic planners. They believe in and have operationalized a planning model to achieve goals for mental health care reform. This Planning Model includes defining a vision, targeting the populations to be served, determining the outcomes to be achieved, establishing what mental health services are needed to enable the target population to achieve these outcomes, determining what resources are necessary to provide these services, forming coalitions to garner these resources, and collecting data for evaluation, system accountability, and marketing purposes. Ventura has been consistent in its dedication to implementing these strategies.
- o **Meaningful Collaboration** - From the outset the Ventura mental health staff was committed to working with other child-serving agencies. Mental health staff physically go to or work in these agencies and become part of the environment and culture of these service systems. Staff of Mental Health, Special Education, Child Welfare and Juvenile Justice work together as teammates. Not only do they collaborate around clients, but they share discussions at the water fountain or over lunch. There are good lines of communication and a high degree of mutual respect and trust. There are also numerous mechanisms at multiple levels that provide a forum for discussion and problem solving -- the Interagency Juvenile Justice Council, the Case Management Council, and the various interagency screening committees. A number of individuals mentioned that as a result of this experience with interagency collaboration, "The

whole is much greater than the sum of its parts." Staff admit they could never return to the old way of doing business

- o **Dedicated Staff** - The Ventura project has changed how mental health staff provide treatment, and, for the most part, staff have demonstrated a willingness to make changes. They are believers in the vision. They understand system issues and are committed to collaboration. They are secure in their talents and abilities and are comfortable with the uncertainty that change often brings.
- o **Service Array** - By leveraging resources, reallocating dollars, and blending funds across agencies, Ventura has been able to expand the service continuum to include an array of community-based services including home-based services, case management, therapeutic foster care, day treatment, and specialized services through the Resource Development Project and CBRA. Having this range of treatment alternatives enables the system to be responsive to youth and families and makes the system "work" for agencies trying to obtain services for clients.
- o **Legislative Mandate** - One of the strengths of the Ventura system is its statutory sanction. Many of the critical elements of the system -- articulating the vision, defining the target population, requiring interagency agreements, and requiring the measurement of outcomes -- are established in law. This mandate gives Ventura the political and legal clout to implement its system of care and institutionalizes the concept of an interagency, community-based system of care.
- o **Evaluation Capability and Successful Outcomes** - Because Ventura was started as a demonstration project and mandated to document cost avoidance and successful outcomes, it has set up an evaluation and tracking system which enables the mental health agency to collect data and report progress in achieving objectives. From the outset, Ventura has had a capable, competent research staff to establish and implement this evaluation system. This system for tracking system accountability and client outcomes has been enormously valuable in documenting systemic impacts and in justifying this approach to service organization and delivery. Ventura leadership believes that the data showing cost savings and client benefits are the reason for the system's survival in difficult economic times. Without this evidence, a new wave of legislators and political leadership might easily have terminated the project in search of different solutions. Instead, the Ventura system has become a model for the state and has been expanded to include the adult mental health service system. Ventura leadership maintains that outcome data are a prerequisite for any system, for future decision making, and for political and financial survival.
- o **Cultural Competence** - Ventura has made a major commitment to improving cultural competence, developing a master plan, hiring staff to work with the county in implementing this plan, conducting specialized

training of staff, and undertaking numerous other activities to improve services to minority groups. While many activities spelled out in the master plan are just being initiated, Ventura is on the cutting edge in this area and is taking a leadership role.

- o **Target Population** - While Ventura has received its share of criticism for strictly limiting the population it serves, system leaders are convinced that having a clear definition of who is to be served with limited public dollars, and establishing criteria for assessment are absolutely essential to the success of a system of care. The target population dictates the services to be developed and the outcome goals to be achieved.

Continuing Challenges

While Ventura has made major progress in developing a system of care and has achieved many milestones of success, it continues to face challenges and problems.

- o **Continued Funding Support** - California, like many states, is experiencing major deficits. Budgets for services are being cut back and agencies are having to serve an increasing population in need with diminishing resources.
- o **Resistance to Change** - As noted, the Ventura staff, for the most part, have embraced change and are ardent supporters of reforming the system. But opposition to change exists. Revamping the outpatient service to serve only the targeted populations and to provide treatment that is radically different from a traditional community mental health center approach has been a struggle. The process is still underway, and staff are still learning how to reorganize and reconceptualize outpatient services to fit in the new system.
- o **Service Development** - The continued development of community-based services and the determination of which services are most needed to fill the gaps represent a continuing challenge. Different parts of the system view the gaps and the needs from varying perspectives. Child welfare personnel see the need for more foster homes; the judges and probation officers are concerned about crowding in juvenile facilities. Other service gaps include a lack of crisis intervention, substance abuse services, and prevention and early intervention. Certain services such as home-based and case management could be expanded if there were more adequate resources.
- o **Family Involvement** - How to meaningfully involve families and respect the decision making of families around appropriate care for their children is an ongoing struggle for Ventura, as it is in other communities. There are situations in which Ventura's system's goals to serve a youth close to home with community-based services and supports may conflict with the parents' assessment of what is best for the child. In these cases, Ventura staff work with families to review treatment options, taking into

consideration parents' concerns. Ultimately, it is the parents' decision. Also different sub-systems relate to families in different ways. For example, there are occasional conflicts between Shomair workers, protective services staff, and foster care parents in decisions to reunify a child with natural parents. However, because of the level of trust established and effective lines of communication, these differences typically can be worked through. Ventura could also benefit from increased parent involvement on the interagency bodies and in the development of support groups.

- o **Systems Issues** - Even given Ventura's efforts to break down system barriers through interagency agreements, joint funding and decision making, and policy level negotiations, bureaucracies do not always work in the most expeditious ways. Legal mandates, court delays, burdensome paperwork, turnover of the Juvenile Court judges, and barriers to using Medicaid for incarcerated youth all represent problems brought up by staff of the various agencies in Ventura.

These are problems confronting many communities trying to establish community-based systems of care. Because Ventura has been a leader in undertaking systems reform, this county will continue to be in the spotlight to see how it addresses these complex issues, thereby serving as a guide to others.

XIII. TECHNICAL ASSISTANCE RESOURCES

Leadership and staff of Ventura County have played an active role in providing technical assistance to multiple constituencies and have generously shared their knowledge and experience in developing a community-based system of care. Staff have presented at numerous national meetings and conferences; conducted site visits for a wide range of officials including federal, state, and local administrators, providers, and foundations; and provided consultation to states and communities upon request. Ventura has also developed a wealth of materials summarizing and describing various aspects of their system. Staff work closely with other California counties and with the state to assist in replication of the Ventura model.

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Profiles of Local Systems of Care

**for Children and Adolescents
with Severe Emotional Disturbances**

INDIVIDUALIZED SERVICES IN A SYSTEM OF CARE

Prepared By:
Judith W. Katz-Leavy, M.Ed.
Ira S. Lourie, M.D.
Beth A. Stroul, M.Ed.
Chris Zeigler-Dendy, M.S.

**CASSP Technical Assistance Center
Center for Child Health & Mental Health Policy
Georgetown University Child Development Center**

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INTRODUCTION

This case study was developed through a project conducted by the Child and Adolescent Service System Program (CASSP) Technical Assistance Center at Georgetown University. It is part of a descriptive study of local systems of care which was initiated in 1990 and funded by the National Institute of Mental Health (NIMH), Child and Adolescent Service System Program. The project has involved identifying and studying communities which have made substantial progress toward developing comprehensive, coordinated, community-based systems of care for children and adolescents who are severely emotionally disturbed and their families. Individual case studies of each local system of care are the products of this effort and are intended as technical assistance resources.

Systems of care for troubled children and adolescents have been of great interest over the last several years. In 1982, Knitzer estimated in her seminal study, Unclaimed Children, that of the three million children with serious emotional disturbances, two-thirds were receiving no treatment whatsoever and countless others were receiving inappropriately restrictive care because of the lack of community-based service alternatives. In 1986, Saxe conducted a study for the Office of Technology Assessment of the United States Congress which confirmed Knitzer's findings and stated that "Mental health problems are a source of suffering for children, difficulties for their families, and great loss for society. Though such problems are sometimes tragic, an even greater tragedy may be that we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available."

In response to these problems and to the growing number of calls for change, the National Institute of Mental Health launched the Child and Adolescent Service System Program (CASSP) in 1984 to assist states and communities in developing community-based systems of care for this underserved population. Through grants and technical assistance activities, CASSP has supported the development of interagency efforts to improve the services provided to the most troubled children and youth and their families. To provide a conceptual framework for system of care development, CASSP supported the publishing of A System of Care for Severely Emotionally Disturbed Children & Youth by Stroul and Friedman in 1986. This monograph has been called a blueprint for action in the child mental health field, and it describes the various service options required by these youngsters and the need for services across all of the relevant child-serving agencies. From these components, Stroul and Friedman proposed a design for a "system of care" encompassing both the full range of services and the mechanisms required for the assurance of their appropriate delivery. Currently, there is widespread agreement that community-based systems of care for youngsters who are severely emotionally disturbed and their families are needed, and the development of these systems has become a national goal.

Despite the calls for such systems of care, until recently there were few, if any, examples of local systems of care which combined an array of community-based services with other essential elements including interagency collaboration and case management. Today, there is what might be described as an explosion of activity related to system of care development. The activities of CASSP, which have now involved every state, have played a crucial role in stimulating system development at state and local levels. Increased attention to children's

mental health by advocacy groups also has had a major impact. Further, system building has been advanced significantly by initiatives such as the Robert Wood Johnson Foundation's Mental Health Services Program for Youth, which has provided funds for the development of systems of care in selected local areas, and extensive system development initiatives in a number of states. As a result, many communities now have evolving systems of care which can be studied and described. Descriptions of the system building approach and experience of these communities are designed to assist other communities which are attempting to develop such systems.

Potential sites for inclusion in this study were identified through a process of consultation with key informants including individuals at national and state levels who have extensive knowledge of developments in the children's mental health field and in the development of local systems of care in particular. Through these initial discussions, approximately 20 communities were identified. These localities were characterized as having made significant progress toward the development of community-based systems of care consistent with the philosophy and principles which have been promoted by CASSP and which are displayed on the following page. Accordingly, an attempt was made to locate local systems which are family focused, emphasize treatment in the least restrictive environment, involve multiple agencies, individualize services, and so forth. Similarly, an attempt was made to locate systems which have moved beyond the more traditional outpatient, inpatient, and residential treatment services and have begun to develop a more complete and balanced array of nonresidential and residential services including home-based services, day treatment, crisis services, therapeutic foster care, respite care, case management and others.

The second phase of the selection process involved extensive telephone interviews with a representative from each site to obtain detailed information about the array of services available in the community, the nature and functioning of the system level coordination mechanisms, and the nature and functioning of the client level coordination or case management mechanisms. In addition, information was collected about any special system activities related to such issues as financing the system, evaluating the system, involving families in planning and delivering services, and enhancing the cultural competence of the system of care. A chart was prepared for each potential site summarizing the service array, system level coordination mechanisms, and client level coordination mechanisms.

Selection of sites for further study was accomplished with the assistance of an advisory committee and was based on the following set of criteria:

1. Must have a range of services in place (home-based services, crisis services, therapeutic foster care, and others).
2. Must have interagency coordination mechanisms in place.
3. Must have client level coordination mechanisms in place, e.g., case management.
4. Must be a sufficiently well-developed local system to be able to serve as a useful example to the field and to receive national attention.

CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.
5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.
6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
10. Emotionally disturbed children should receive culturally competent services which are sensitive and responsive to cultural differences and special needs and are provided without regard to race, religion, national origin, sex, physical disability, or other characteristics.

5. Should have some noteworthy activities in one or more areas including family involvement, cultural competence, transition, high-risk children and adolescents, financing, and evaluation.

An initial group of five communities was selected for site visits by the project team. The site visits generally involved spending three to four days in each community engaged in a variety of activities designed to provide insight into the functioning of the system of care. These activities included interviews with a number of individuals and groups including key system managers, senior management representatives of the major child-serving agencies (mental health, child welfare, education, and juvenile justice), case managers, youngsters, parents, and advocates. Additionally, the schedules included visits to three or more service components in the system of care where activities were observed and discussions held with program managers, staff, and, in some cases, clients. An important aspect of the site visits was observing the functioning of interagency entities. Site visitors attended meetings of interagency entities focusing on system-level coordination as well as meetings of interagency teams organized for the purpose of creating individualized service plans for specific youngsters and their families. The site visits provided a wealth of information about each system of care -- its developmental milestones, strengths, and obstacles yet to be overcome.

The sample of communities studied yield valuable insights into the process of building systems of care. Due to an enormous increase in system development activities in communities across the nation, there currently are many more noteworthy examples of local systems of care. It should be emphasized that none of the communities selected for study have fully developed systems of care, and all are struggling to overcome financial and other obstacles to system development. Rather, they are communities which have succeeded in putting some basic building blocks into place and have demonstrated progress toward achieving system development goals. The resulting case studies are intended to serve as technical assistance resources for other states and communities as they approach the challenge of developing local systems of care for youngsters with severe emotional disturbances and their families.

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INDIVIDUALIZED SERVICES IN A SYSTEM OF CARE

I. OVERVIEW OF THE PHILOSOPHY AND PROCESS

Since the landmark publication of Unclaimed Children (Knitzer, 1982) by the Children's Defense Fund, considerable effort has been made to improve services for children and adolescents with serious emotional or mental disorders and their families. Through the federal government's establishment of the Child and Adolescent Service System Program (CASSP) in 1984, there has been a substantial increase in the awareness and understanding of the needs of these children and families. CASSP was created by Congress with the understanding that: 1) the current service system was fragmented; 2) children who needed to be served were being cared for in all sectors of the service system including mental health, child welfare, special education, and juvenile justice; and 3) the children with the most severe problems were being served under the aegis of a single public agency while their service needs actually spanned several systems (Lourie & Katz-Leavy, 1992). The goal of CASSP was to improve the way in which children and adolescents with or at risk of developing serious emotional or mental disorders and their families were offered multiagency services.

Stroul & Friedman (1986, 1988) presented a conceptual framework for a "system of care," encompassing the full range of services and the mechanisms required for the assurance of their appropriate delivery. In this monograph, the first core value was that a "system of care must be child-centered, with the needs of the child and family dictating the types and mix of services provided." The importance of tailoring services to the specific needs of the child and family was further emphasized in one of the 10 guiding principles for the system of care which stated that "children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan." Thus, the concept of individualizing services was very much a part of the original "system of care" philosophy. While the concept of individualizing services has been widely accepted as a basic premise for systems of care, the actual power and potential of this approach has been developed during the past eight years, beyond anything imagined in 1986.

It should be noted that, even before 1986, certain aspects of individualizing service planning were being implemented by practitioners. "Within particular service components, be it outpatient therapy, day treatment, or therapeutic foster care, for example, many clinicians have always tailored the service to meet the needs of each child and family" (Friedman, 1988). Additionally, the push to expand the range of community-based services within the system of care was based on the recognition that more options needed to be available to adequately meet the unique needs of different children and families. Home-based services, day treatment, therapeutic foster care, crisis services, respite care, and others are among the services that communities are adding to their systems of care. Intensive case management is one service that is increasingly being utilized to individualize services. Intensive case managers with small caseloads work to customize services for each youngster and have "the independence, the knowledge, and the creativity to insure that an individualized plan is developed and implemented" (Friedman, 1988).

Another evolving aspect of individualizing services has been the provision of funds or staff resources in a flexible manner that permit case managers to "wrap services around" the needs of children and families rather than require them to fit into existing programs (Friedman, 1988). The term "wraparound" was coined in North Carolina (Behar, 1985), and the approach has rapidly expanded to numerous states and communities throughout the country. This approach permits a case manager, treatment team, or service program to add new services, both traditional and nontraditional, specifically designed for individual youngsters and/or families to enable them to achieve the goals specified in a customized service plan. The approach is most successful when applied in a flexible and creative manner. Although a similar type of individualized service approach has been successfully applied in the developmental disabilities field as part of deinstitutionalization efforts, it is relatively new in the field of children's mental health.

In order to clarify these new developments, and to consider their relationship to the concept and philosophy of a community-based system of care, it is proposed that "individualized services" be viewed as both a philosophy and a process. As a philosophy, individualized services are based on six underlying values: focusing on an individual child and family; providing services in the most normalized environment; establishing a partnership with families; using a strengths-based, ecological orientation; ensuring cultural competence; and providing unconditional care. As a process, individualized services are based on four key strategies or approaches: interagency collaboration, case management/care coordination, wraparound services, and flexibility of funding and services.

Philosophy and Values

The philosophy and values underlying individualized services are very similar to the philosophy for a system of care described by Stroul and Friedman (1986), which specifies that systems of care should emphasize the provision of services that are comprehensive, individualized, coordinated, provided in the least restrictive environment, involve families as full partners, and culturally competent. Many communities currently are basing their developing systems of care on these values and principles. Within this overall value system, the individualized care approach emphasizes six major underlying values:

- o **Focus on an Individual Child and Family** - The first underlying value is that individualized services, as the designation suggests, are applied to one child and family at a time. This approach allows the creation of a service plan which is designed specifically to address the unique needs and strengths of each child and family. Tannen (1991) described the approach as highly child and family centered, with the goal of empowering each child and family so that they can effectively manage their lives. Burchard and Clark (1990) stated that individualized care involves a "total commitment" to serve each child and family on an individual basis and to provide services for as long as there is a need. Thus, rather than only focusing on groups of youngsters within the confines of a specific agency or program, the focus in the individualized care approach is on meeting the needs of one child and family at a time.
- o **Services Within the Most Normalized Environment** - A second value emphasizes providing services within the most normative environment. All activities and services

in the individualized care approach are geared toward enabling youngsters to remain in the least restrictive, most normalized environment and to live as normal a life as possible. The first option, always considered most preferable, is to enable the child to remain within his or her own family. If this is not possible, all efforts are made to enable the youngster to remain in the community in a family or family-like setting. Therapeutic foster homes often are the treatment environment of choice for youngsters who cannot reside with their own families or supported independent living for older adolescents. This value is based upon the strong beliefs that youngsters should reside with their families or in family settings and that intensive treatment services can effectively be provided within these normative environments. VanDenBerg (1991) defined normalization as supporting lifestyles as similar as possible to the youngster's peers and emphasized that services and resulting lifestyles should be as culturally, ethnically, and age appropriate as possible.

- o **Partnership with Families** - Inherent in the individualized care approach is the notion of creating a partnership with families. Since the entire process depends upon addressing the child and family's needs in a holistic manner, it would be impossible to plan and implement individualized services without a close collaborative relationship with the family. Individualized services are dependent upon parent involvement during all phases of services delivery, including participating on the interagency service planning/treatment team, developing the individualized service plan, and monitoring and evaluating progress. As noted by Tannen (1991), the child and parents are included in every phase of individualized services and they are always listened to and treated with respect by professionals.
- o **Strengths-Based, Ecological Orientation** - Using a strengths-based, ecological orientation represents another underlying value of individualized care. A thorough assessment of the child and family's strengths, needs, and desires forms a basis for the development of an individualized intervention plan. While traditional assessments tend to emphasize pathology and service needs, assessments for individualized care emphasize the child's and family's assets as well as their deficits. As stated by Olson, Whitbeck, and Robinson (1991), the strengths-based orientation allows the child and family to be seen as individuals with unique talents, skills, and life histories as well as having specific unmet needs. This orientation recognizes the fact that even the most troubled youngsters and stressed families have strengths, assets, and coping skills that can be built upon when creating an intervention approach. Further, the strengths-based assessment is not limited narrowly to the mental health domain, but takes an ecological approach to consider the child and family across all environments and life domains, including residential, family, social, educational, vocational, medical, psychological, legal, safety, and others. This strengths-based, ecological perspective not only drives the assessment, but becomes the key factor in the development of the individualized service plan for the child and family.
- o **Cultural Competence** - Cultural competence is the fifth underlying value of individualized services. The need for culturally competent services was recognized as the system of care concept was developed; one of the guiding principles specifies that children should receive culturally competent services which are sensitive and

responsive to cultural differences and special needs. While there has been discussion of the need for culturally competent services (Cross, Bazron, Dennis, & Isaacs, 1989; Isaacs & Benjamin, 1991), progress in this area has been slow. Individualized services, focusing on one child and family at a time, are uniquely able to take cultural and ethnic factors into consideration as the service plan is developed. VanDenBerg (1991) emphasized the importance of ensuring that services are culturally, ethnically, and age appropriate. The application of this value in planning and implementing services is facilitated by the strengths-based, ecological assessment, which allows the interagency service planning team to learn about the child's environment prior to planning and delivering services. The incorporation of cultural competency into this assessment of strengths, needs, and design of the service plan means that efforts are made to learn about cultural and ethnic issues which impact on the child and family and to understand and respect their values. The value further implies that providers work closely with referral agencies to ensure that children of color are appropriately identified and referred for services.

- o **Unconditional Care** - The final value of individualized care is that of unconditional care. This value has two primary components -- an inclusive intake policy and a policy preventing punitive discharge. An inclusive intake policy specifies that no youngsters may be rejected or found ineligible for individualized services on the basis of the severity of their presenting problems. Thus, youngsters are eligible for services no matter how serious, complex, or difficult the problems. The second aspect of unconditional care holds that, once a youngster is found eligible for services, a long-term commitment is made to the child and family, and the providers do not give up on the child no matter what the child may do to jeopardize that commitment. Adherence to the value of "no punitive discharge" means that no youth is dropped, discharged, or ejected from services due to challenging or disturbed behaviors or other needs. Rather, the commitment of unconditional care obligates the providers to do "whatever it takes" to ensure that the youth receives clinically appropriate services within the least restrictive setting. Providers reconfigure services to meet crises and changing needs rather than dismissing youngsters or referring them elsewhere. Burchard (1988) noted that the commitment to unconditional care breaks the cycle of rejection that so many troubled youth experience.

The origins of this value can be traced to Browndale, an agency which was founded in the 1960s in Canada and which provided group home services based upon the philosophy of unconditional care (Dennis, 1992). Kaleidoscope, founded in Illinois in 1973, adopted this philosophy of unconditional care, further defining it to mean both "no reject" and "no eject" from services. Kaleidoscope's founders and staff were determined to stick with the youngster no matter where he or she ended up. If the youth ended up in juvenile corrections or in jail, they would follow the youth there, and they would be there to offer support when the youth was released. This underlying value became a critical factor in hiring staff; a conscious effort was made to select only providers who believed in this kind of commitment and could accommodate to the flexibility such a commitment required. Unconditional care has become a cornerstone of individualized services and is a basic tenet of most individualized care efforts.

In describing the Alaska Youth Initiative, Dowrick (1988) wrote "the real reason that this works, the real key, is because someone takes the responsibility; someone stops the buck. There must be somebody who is in the position to say, 'Yes, we will take care of these children, no matter what they do. If they try to kill themselves, try to kill each other, if they are sexually promiscuous, destroy things, set fire to buildings, assault one another, or generally drive people up the wall, we will take care of them nonetheless. One person will take responsibility.' We will not say, 'This person has a learning disorder, therefore, we can't deal with him. This person has mental retardation, that's not our population. This person is sixteen, she's too old. This person has a criminal record, that's for juvenile justice, and so on.' We won't pass this child around anymore. We will take care of this child."

Several illustrations of the underlying philosophy and principles of individualized services were presented by the Director of Kaleidoscope in Chicago at the First National Wraparound Conference held in Pittsburgh, Pennsylvania (Dennis, 1992). He first described the case of "Allen," a youth presenting serious and complex problems for whom Kaleidoscope successfully provided care using an individualized approach.

Allen was a young 16-year-old juvenile who had been rejected from several residential treatment centers. He was now being rejected from a correctional setting where he was considered too difficult to handle after tearing a door off an isolation cell. Everyone thought that he was incorrigible. Yet no matter where he was placed, no matter how far from his home and neighborhood, it was noted that his mother faithfully visited him twice a month. Based upon the strength of this apparent relationship, Kaleidoscope designed an individualized service plan for Allen.

Despite the fact that she was extremely devoted to this son, Allen's mother was adamantly opposed to his return home; in fact, her state caseworker also counseled her not to let Allen come home. Undaunted by Allen's mother's resistance, Dennis prevailed upon her sense of hospitality to let him come in and play "a little game." This game was: "If he could wave his magic wand, what would it take for Allen to be able to come home?" If she would just do this for 10 minutes, then Dennis would leave and not return. Eager to get rid of this uninvited visitor, Allen's mother agreed to participate.

With each wave of the wand, Allen's mother came up with another condition for her son's return:

- o Someone to come to their home and get Allen up for school;
- o Someone to be with Allen in school to help him control his temper;
- o A therapist who wouldn't be afraid or give up on Allen even if it meant having a companion sit in on each session to help control Allen's violent outbursts;
- o Someone to give her a few free hours of time each day when she came home from work; and
- o A 24-hour crisis plan for evening, weekends, and holidays to ensure her safety when Allen became agitated.

Allen returned home the following week, but this time his mother had the support services she had helped to design. There were still crises, but they were anticipated, and everyone

had agreed in advance how they would be handled. Ultimately, Allen was able to move into transitional community housing and participate in a supported work program.

This vignette illustrates a number of the underlying values of individualized services -- focusing on the needs of one child and family, providing services in the most normal environment (the child's home), forming a meaningful partnership with families, and building an intervention plan using a strengths-based orientation. The Kaleidoscope staff knew that a major strength in this family was Allen's mother's love for him, but also knew that she needed meaningful support services if she was going to be able to cope with him. A program of support services was tailored to meet Allen's individual needs and those of his mother. It was designed around the strengths of both the youngster and his family, and it enabled him to return to his home and community.

Dennis also presented an important illustration of the need for another value of individualized services -- the incorporation of cultural competency into the assessment of strengths and needs and into the design of the service plan. Nancy, a six-year-old Native American girl, had recently moved into a new school away from her traditional tribal home. She was found regularly stealing from her schoolmates. Her teacher and the administrators of the school, who really cared for Nancy but had no knowledge of Native American customs, felt that she was becoming more and more depressed as the stealing continued. They recommended that she be placed in a residential treatment center. However, in a last attempt to understand Nancy, a Native American who is an expert in the area of cultural competence was enlisted as a consultant. He immediately knew that Nancy did not understand the concept of individual ownership. In her culture, material possessions belonged to everyone under a belief in shared ownership among her tribe -- children played with a toy at one house and left it at the next. This, of course, did not necessarily rule out the possibility of depression. It does, however, point out the importance of understanding the values and customs of the people and the need to constantly question our own assumptions and consult others who possess the necessary knowledge when in question.

In another reference to cultural competence, Dennis pointed out the pitfalls of removing children from their own communities and natural support systems and underscored the need to take the time to learn about another's culture. To illustrate this point, he described a tall African American young man who had spent the first 14 years of his life living in Cabrini Green, considered the most depressed and dangerous housing project in America. He was now returning to his birth community after spending the last three years in a residential treatment center far removed from his natural surroundings. When Dennis asked what his favorite sports were (expecting him to reply basketball due to his height), he responded that they were fencing and polo. These were the sports he had been exposed to in the very well-meaning residential treatment center, but they were not skills which would be useful to him in an urban environment. In addition, he had no community skills, no street smarts. He had lost all contact with his family and friends and had lost his community support system.

Process

As noted, individualized care can be viewed as both a philosophy and a process. The process of individualizing services includes four major features: interagency collaboration, case management/care coordination, wraparound services including an array of traditional and

nontraditional services, and flexibility of funding and services. It should be noted that these processes which characterize individualized services are the same processes which should characterize an effective, community-based system of care (Stroul & Friedman, 1986). The individualized care approach has further developed these processes and shown how they can be systematically applied to meet the needs of each child and family.

- o **Interagency Collaboration** - Interagency collaboration, the first of these features, appears to be an indispensable aspect of providing individualized care. In a recent nationwide survey of 15 different programs based on the individualized services approach, MacFarquhar and Dowrick (in press) asked the question, "What single factor contributes most to the success of your program?" The largest percentage of respondents (42 percent) indicated that an interagency team was the most important factor in the program's success. Of the programs surveyed, 93 percent used an interagency collaboration approach, based upon the use of some form of interagency service planning/treatment team. Programs using a team approach reported that decisions about service delivery were made as a team. Several communities worked on a two-tiered team approach. A youth-specific team was responsible for service planning and implementation, and a higher-level interagency team of some type reviewed more complex cases, approved unusual service or funding arrangements, and focused on system-level issues related to service delivery and interagency relationships. In addition, many states utilize a state-level interagency team to focus on broad system and policy issues related to service delivery and, in some situations, to review and resolve cases which cannot be resolved at the local level. It is the interagency youth-specific team that has been adopted almost universally by individualized service programs across the country.

The team approach appears to be helpful in a number of different ways. More complete information is obtained about the child and family since contributions are made by all involved parties, not just one or two agencies. Greater resources may become available by combining the staff and services of multiple agencies, and the workload and responsibility for time-consuming and complex cases are shared among multiple agencies. Further, the creativity and energy of the group process are harnessed in planning for the child. A time-limited case conference format may be utilized to maximize utilization of staff time and to keep committee members focused. The benefits of using an interagency team were noted by Friedman (1988) when he wrote that, "First, by convening a team of individuals who are knowledgeable about the child, including parents where possible, the likelihood of having a complete understanding of the child is enhanced. Second, since the individuals on the team may all be involved in implementing the service plan, the meeting is useful in providing all with an opportunity to give input and in gaining everybody's support for the plan. Third, the process of creative treatment planning can be facilitated by having a group of individuals with different perspectives rather than just one or two people." In addition, Burchard and Clark (1990) wrote, "Having an interdisciplinary care team allows for tracking services across agencies and makes individualized care easier to implement. It promotes shared ownership and makes it less likely that an individual or an agency will act without consensus. Communication is a critical function of the interagency team." An additional benefit is that team participants may begin to think more broadly about the functioning of the system of care in a

community and often may initiate system improvements based upon their interactions relative to the needs of individual youngsters. Further, as team members become more familiar and comfortable with the process of individualized services, they often bring these concepts back to their own agencies and begin to apply them to other populations, for example, to other youngsters in the juvenile justice system who may not have severe emotional disturbances (Hernandez, 1992). In LaGrange County, Illinois, the education system has taken the initiative to implement individualized services with interdisciplinary teams and flexible funds to keep youngsters in the community.

- o **Case Management/Care Coordination** - In all systems of care, some form of case management or care coordination plays a critical role in planning, orchestrating, monitoring, coordinating, and adjusting services. Behar (1991) proposed that clinical case management is the "key to systemic success" in a complex system of services by virtue of providing consistent advocates for the client and family and by coordinating and monitoring all services throughout the course of treatment. Behar (1985) also stated that "Case management, in its most positive sense, has emerged as: (a) the element of planning and coordination that has combined the workings of all agencies concerned with the child, (b) the energizing factor that has propelled the service plan into the reality of service delivery, and (c) the case advocacy strength that has sustained a commitment to each child and an optimism about each child's capacity to change." For individualized services, case management plays an especially crucial role.

The case management/care coordination function has been described by a number of different terms. Young (1987) put forth a model of therapeutic case advocacy and described its usefulness in creating "an individualized system of care" for each child with an emotional handicap and his or her family. North Carolina describes a program of clinical case management (Behar, 1991), and the Alaska Youth Initiative refers to an individualized services coordinator, also sometimes referred to as a youth-specific services coordinator, a family assistance coordinator, or a local coordinator. The Vermont New Directions Program, which is supported through a grant from the Robert Wood Johnson Foundation, refers to this concept as therapeutic case management.

While there is a diversity of terms to describe this function, it is clear, nevertheless, that some form of intensive case management plays an integral part in most individualized services for children with serious emotional or mental disorders and their families. In a number of sites, the case manager is responsible for conducting the ecological assessment and for bringing this preliminary work to the first meeting of the interagency team. In most cases, the case manager performs a facilitative role within the interagency team throughout the process of developing an individualized plan of services for a specific child and family. The case manager is then responsible for ensuring that the plan is implemented and that appropriate coordination across agencies occurs. The case manager also makes sure that mechanisms are in place to ensure frequent communication and to identify the need for changes in the plan if it is not meeting all of the life domain needs of the child or family, preferably before crises occur.

- o **Wraparound Services** - Individualized services draw upon all available resources for children and families -- formal and informal, traditional and nontraditional. The process of individualizing care incorporates the concept of wraparound services as an integral feature. Behar (1986) outlined a rationale for setting aside "flexible" dollars to pay for nontraditional services which often are needed to help troubled youth remain in the community and participate in traditional service programs. As an example, wraparound funds could be used to pay for respite services to give stressed parents a break, to allow a youth to pay apartment-related expenses, to enroll in recreational activities, and to purchase otherwise unavailable items and services important to maintain a specific child in his family or surrogate family in the community. The concept of wraparound services currently is applied more broadly to connote the creative combination of all types of services, resources, and supports which are needed by a youngster and family.

The International Initiative on the Development, Training, and Evaluation of Wraparound Services (1992) defines wraparound services as interventions which are "developed and/or approved by an interdisciplinary services team, are community-based and unconditional, are centered on the strengths of the child and family, and include the delivery of coordinated, highly individualized services in three or more life domain areas of a child and family." As described by Burchard (1988), the underlying foundation of wraparound services "is to identify those children that are the most severely emotionally disturbed and wrap services around them to facilitate their adjustment in the mainstream." A thorough, ecological assessment, completed by the case manager and interagency team, is used as the basis for identifying strengths and needs and for developing an individualized service plan which addresses all life domains and which includes both existing services and other services and supports devised in response to specific needs.

MacFarquhar and Dowrick (in press) reported that all programs responding to their survey had the flexibility to design services and supports beyond traditional mental health programs. They provided some examples of wraparound services purchased with flexible dollars including hiring foster parents with an apartment on their property which would allow a youth to move back and forth between foster care and independent living as necessary and buying an auto part needed for repairs to provide transportation to therapy for a youth and family. Other examples consisted of providing a paid friend to supervise a youth in the community in order to promote socialization; providing a hotel room with supervised staff until appropriate placement was available after discharge from a psychiatric hospital; and purchasing a washing machine for a family whose child had enuresis. Programs across the country have used flexible dollars to wrap services around the child and family in areas including family support and sustenance, therapeutic services, school-related services, medical services, crisis services, independent living services, interpersonal and recreational skill development, vocational services, and reinforcers. The types of services and supports that can be provided to a child and family through this approach are constrained only by the limits of the creativity of the case manager and participants of the interagency service planning/treatment team.

Thus, in addition to capitalizing upon and utilizing existing services and programs within the community's system of care as appropriate, individualized service plans are enriched by the addition of wraparound services which are used to ensure that the individualized service plan is able to appropriately address all of the child's life domains. It is the creative combination of services and supports of all types for a child and family which characterizes the individualized service approach and which enriches a system of care, tremendously increasing its capacity to help troubled children.

- o **Flexibility of Funding and Services** - The fourth essential feature of the process of individualizing services is flexibility -- flexible funding and flexible care. Individualized services cannot be provided without flexible funds which can be used to purchase or create the services specified in the individualized intervention plan. The concept of flexible funding requires that the money for purchasing the services follow the child in that it is available to serve the child regardless of the program the child is in. "In terms of logistics this is the linchpin of individualized care. In order to provide care that is unconditional, child-and-family centered and flexible, it is essential that money is attached to the child for the purchase of services and not to a program for the delivery of services" (Burchard & Clarke, 1990).

According to MacFarquhar and Dowrick (in press), this change in the way funding is conceptualized reflects a primary principle of individualized care. Money are attached to each child to develop services and supports, and funding of services can be shifted as the treatment plan changes. Although flexible funding is considered an indispensable feature of individualized care, a substantial proportion of the programs included in MacFarquhar and Dowrick's survey (25 percent) indicated that funding is the most significant problem they face. The reported problems lie in acquiring adequate funding to provide individualized care as well as in the ability to use funds in a flexible manner. Many states and communities currently are experimenting with a variety of approaches to flexible funding. Strategies include creating a pool of blended funds from the various child-serving agencies which can be accessed by case managers and/or interagency teams to pay for individualized intervention plans. Additionally, an increasing number of service programs across the country (such as home-based service, day treatment, therapeutic foster care, and other programs) are budgeting various amounts of flexible funds to purchase wraparound services and supports for participating youngsters and families.

Not only should funds be flexible, but services themselves must be flexible under an individualized care approach. "Flexible care requires services which can arrive when needed and then be increased and decreased in intensity, based on the needs of the child and family" (Burchard & Clark, 1990). Children with serious emotional or mental disorders move in and out of programs on a frequent basis and their needs can fluctuate markedly on a weekly or even daily basis. If services are to be tailored to their needs, it is critical that the case manager have the resources and the authority to respond in a timely and flexible manner. Flexible care is based on the ability to change the service plan as frequently as necessary. In the individualized approach, if the child and family's needs are not being met, the service plan is changed rather than expelling or rejecting the child. Implicit in the commitment to provide flexible

services is a commitment to do whatever it takes to meet the needs of the child and family over the long-term.

The Alaska Youth Initiative has developed a strategy to ensure flexibility of service delivery involving a weekly assessment by case managers of how well the individual child's and family's needs are being met. The program has developed a Proactive Client Tracking System (PCTS), which consists of a weekly subjective assessment of a child's adjustment by each adult team member and relevant service providers. If it appears that the child's needs are not being met, the case manager can immediately convene the interagency treatment team to readjust the individualized service plan. If a shift in the plan needs to be made before the team is able to meet, expenditures can be changed with an authorizing signature of any two team members. This procedure provides a systematic way to prevent or at least reduce the frequency of unanticipated crises, to rationally plan for needed changes in services, and also to respond quickly when crises do occur. Such flexible response mechanisms are built into most individualized service programs.

II. OPERATIONALIZING INDIVIDUALIZED SERVICES

In order to implement individualized services, decisions must be made in a number of key areas including: how to define the target population; how to organize and utilize interagency service planning teams; how to fulfill the case management/care coordination function; how to conduct assessments, plan, and provide services; and how to finance individualized services. Each of these issues is discussed below.

Defining the Target Population

The individualized service approach has been used extensively by many states and communities as a mechanism for facilitating the return of children from out-of-state residential treatment settings. During the mid to late 1980s, several states launched initiatives to bring youngsters home from such out-of-state placements, relying upon intensive, individualized services in the community as the alternative. For example, 39 youngsters were returned home from out-of-state facilities through the Alaska Youth Initiative (AYI); individualized services were used in Arkansas to return 47 youths from out-of-state placements. Reportedly, neither state has placed additional youngsters in out-of-state facilities in subsequent years. A number of additional states have, or are currently in the process of, utilizing the individualized service approach to return children who have been receiving treatment in out-of-state settings.

As the potential of individualized care has become more apparent, many states and communities have begun to expand its use to a broader population than children in out-of-state residential care. Based upon a review of eligibility criteria across a range of communities, it appears that such criteria typically require that candidates for individualized services have a serious emotional or behavioral disturbance, functional impairment, and multiagency involvement. Two additional criteria appear to be most salient in defining candidates for individualized care:

- o Youngsters placed in, or at risk for, placement in out-of-community residential treatment settings, and
- o Youngsters with complex and difficult problems whose needs are not being met within the framework of the existing service system.

Virginia, for example, specifies that a child may receive interagency individualized services if the child has emotional and behavioral problems and currently is in or at imminent risk of entering purchased residential care. Another eligibility criterion specifies that services for a child must be unavailable, inaccessible, or beyond normal agency services or routine collaborative processes across agencies. Similarly, AYI guidelines indicate that referral for AYI services should be based upon the caseworker's assessment that the generic service system in the youth's community has been exhausted, and as a result, the youth is judged to be at high risk for a placement outside of the community or out of state. In Washington, intensive community support projects, which use an individualized service approach, focus on the most visible cross-system children who have few options and are most likely to be removed from their homes and communities.

West Virginia also targets youngsters who are referred for, or at imminent risk for, out-of-home placement and whose service needs are so complex and unique that they cannot be met through the typical referral process. The Vermont New Directions Program has designated four target groups to be phased in for services in order of priority: 1) children and adolescents already in out-of-state placement; 2) children and adolescents at risk of, or already in, out-of-home placements within the state; 3) children requiring multiple services who have been referred to the local or state interagency team to resolve problems; and 4) finally, all other children with serious emotional disturbances requiring multiple services.

These criteria suggest that individualized services are being provided to those youngsters considered the most difficult to serve. This observation is confirmed by data collected by MacFarquhar and Dowrick (in press) indicating that programs were serving youngsters with multiple and severe problems which have a profound impact on their lives, and whose prognosis is for long-term care and services. In the programs they surveyed, 71 percent of the youngsters being served were receiving special education, and 64 percent were in state custody. Further, across programs the youngsters had an average of four prior psychiatric hospitalizations, some extremely long-term, and an average of seven failed residential placements. Despite the high level of maladjustment among this client population, the respondent programs reported that these youth were successfully served with individualized services and that only a small percentage of youngsters were considered "too risky" to serve in the community. Tannen (1991) also noted that, in Vermont, some of the most difficult children have made remarkable progress through individualized care.

While states and communities have tended to target a subset of youngsters with emotional disorders for individualized care, it is important to note that all youngsters could benefit from more individually tailored service approaches. A goal for many systems of care is to increase the population of youngsters targeted for individualized services as well as to ensure that all service programs within the system of care are provided in a more flexible, individualized fashion.

Using Interagency Service Planning/Treatment Teams

As noted, MacFarquhar and Dowrick (in press) found that interagency collaboration was the factor most frequently chosen by respondents as leading to the success of individualized services. In fact, 93 percent of the programs surveyed used an interagency team approach to providing services. This interagency team approach most often involves the creation of a team, which is specific to each youth and family and which is composed of the persons most involved and influential in the child's life. This team typically is organized by the case manager and includes the parents and the youngsters themselves, depending upon their ages and maturity levels. VanDenBerg (in press) specified that the team should include, at a minimum:

- o The parent and/or surrogate parent (i.e., foster parent, therapeutic foster parent, or guardian);
- o If the child is in custody, the appropriate representative of the state (social worker or probation officer);
- o A lead teacher and/or vocational counselor;
- o If the child is in mental health treatment or should be in mental health treatment, the appropriate therapist or counselor;
- o A case manager or services coordinator (a person who is responsible for ensuring that the services are coordinated and accountable);
- o An advocate of the child and/or parent;
- o Any other person influential in the child's or parent's life who may be instrumental in developing effective services, such as a neighbor, a physician, a relative, or a friend; and
- o The child, unless to do so would be detrimental to the development of the child.

The group may be expanded to include other professionals who are serving the child or who will potentially receive the child in a program. Such teams have been given a wide range of labels including service network, individual support team, interagency treatment team, core services team, family assessment and planning team, family service planning team, community support team, creative community options team, and others. Despite the wide range of labels, the role of the interagency service planning/treatment team is remarkably consistent across states and communities. With the case manager playing a facilitative leadership role, the team meets and works together over time to develop and implement a comprehensive, individualized service plan for the youngster and family. The plan developed by the interagency team generally is holistic and addresses all of the child's life domains. The team meets as needed to monitor progress and to reconfigure the service plan and approaches based upon the child's changing needs. The team may meet more frequently during early phases of service delivery as the plan is being developed; subgroups may meet at times to resolve emerging problems. Thus, the emphasis for interagency service planning/treatment teams is on reaching consensus among the various participants on the complement of services and supports needed by the child and family and on working together to design, provide, monitor, and revise the package of individualized services and supports as changing needs dictate.

In some communities, an interagency team with a standing membership is used as the focal point for planning and implementing individualized services. This standing team may be

comprised of a core group of regular members who are supplemented by persons involved with the particular youngster under consideration at the time. Florida's family service planning teams, mandated statewide, are examples of standing interagency groups which are supplemented with individuals specific to the youth under consideration for purposes of developing and implementing an individualized service plan.

An alternative approach adopted by an increasing number of communities involves organizing a multilayered system of interagency collaboration which separates client-level functions from system-level functions in the community's system of care. Washington State, for example, uses an interagency coordinating mechanism (ICM) comprised of administrators of each of the child-serving systems to provide system-level coordination. For each child, an individual support team is constituted to develop and adjust individualized "tailored" services (Olson, Whitbeck, & Robinson, 1991).

In Vermont, child-specific interagency treatment teams are used to develop individualized plans for children. If funding, program, or policy problems impede the design or implementation of the plan, the case is referred to the second level -- the local interagency team. Vermont's local interagency teams are responsible for individual case review as well as system-level issues such as improving local services, addressing and resolving policy and funding barriers, and improving interagency collaboration. On the rare occasion that cases cannot be resolved at this level, the State Interagency Team may be enlisted in problem solving.

In Stark County, Ohio, a three-tiered system has been created for individualized case planning and review. A "creative community options" team is organized for each individual youngster and family to assess strengths and needs and develop an individualized service plan. The stated purpose of the creative community options group is to creatively examine what might work for the child and family and to develop comprehensive, individualized service strategies. The case manager is responsible for monitoring implementation of the plan, and the group can be reconvened to address unresolved issues or changes in the child or family's situations. If the creative community options group is unable to resolve difficult and complex barriers to serving a child and family effectively, a referral can be made to the second level of interagency service planning, the ACCORD (A Creative Community Options Review Decision). The ACCORD is a standing committee of mid-level managers who represent each of the major child-serving systems and who are empowered by their agencies to make decisions and commit resources to support creative individualized services. Cases which still cannot be resolved at the ACCORD level can be referred to the Stark County Interagency Cluster, a group comprised of executives of the child-serving agencies with the primary purpose of system-level planning and coordination (Stroul, 1992). Like Vermont, cases which cannot be resolved at the community level may be referred to the State Level Interdepartmental Cluster. The experience of a number of states and communities indicates that both child-specific interagency service planning teams and interagency entities focusing on system-level issues appear to be essential elements of effective systems of care.

The inclusion of the parents as full participants on the interagency team is essential for individualized service approaches. Unless precautions are taken, most parents find attending a service planning meeting with numerous professionals to be an intimidating experience. Steps can be taken to help parents feel more at ease at an interagency team meeting and to

make their participation a positive experience. In several Florida communities, a parent volunteer who has previously attended interagency meetings contacts the parents prior to a scheduled meeting. The volunteer briefs the parents on the interagency process, explains what is expected of them, and answers questions. Other strategies involve sending written materials to parents prior to interagency team meetings and using the case manager to brief and prepare the parents. In West Virginia, a videotape describing the interagency case conference procedure is being prepared as a briefing tool for parents. Involvement of parents in the interagency service planning process is critical for the development and implementation of a successful individualized care plan, although team members may show some initial resistance. In most instances, initial anxiety and resistance to parental involvement is reduced once individuals have participated in a few meetings involving parents.

In order to enhance the efficiency of the service planning process, some communities have developed specific formats or time frames to guide the activities of the interagency team. In Leon County, Florida, for example, approximately 20 minutes are devoted to presentations from the primary caseworker, staff, and family; 40 minutes are then devoted to identifying key issues and developing an individualized interagency plan. In Stark County, Ohio, the Creative Community Options team outlines the history, prepares a people map, identifies strengths and problems, what works, what doesn't work, what the child needs, and options to meet needs. Without some structure, a service planning meeting may become a lengthy and less productive process. All client and family information discussed or distributed at interagency team meetings is considered confidential. Typically, a single release form is used to obtain the consent of the parents for the exchange of information among the specific agencies involved on the interagency team.

Using Case Management/Care Coordination

Weil and Karls (1985) define case management as a set of logical steps and a process of interaction within a service network which assure that a client receives an array of services in a supportive, effective, efficient, and cost-effective manner. The role of case managers/care coordinators includes a range of functions (planning, accessing, linking, advocating, monitoring, supporting, coordinating, brokering, educating, and others) which serve to integrate and maintain a network of services and supports for each child and family. An individualized service approach requires a much more proactive and creative care coordination role than may be associated with a typical case manager. In fact, a more intensive form of case management, performed by highly skilled case managers, is required based upon the challenges presented by the youngsters served and the complexity and uniqueness of their intervention plans. In addition, the individualized care approach needs one individual to function as the coordinator of the interagency service planning/treatment team; that individual most frequently is the case manager.

In describing therapeutic case management in Vermont, Santarcangelo (1990) indicated that the therapeutic case manager carries out all the usual functions of a case manager, but two additional functions have been added: 1) brainstorming with the treatment team to develop interventions and creative strategies to overcome obstacles, and designing services when none are available through existing programs; and 2) providing, with the local interagency team, ongoing education and public awareness efforts directed towards parents and members of the

community on the integration of children with serious emotional or mental disorders into the community.

It should be noted that the term "therapeutic" in "therapeutic case management" does not mean that the case manager is providing treatment per se. In attempting to construct and implement individualized services for the child and family, the therapeutic or clinical case manager seeks to modify environments. According to Young (1987), therapy or mental health treatment is one possible modification of a child's environment. What is therapeutic about therapeutic case advocacy or management "is the recalibration of expectations, instruction, support, and reward in each sector of the child's environment encompassed by the system of care. These changes make the child's interaction with it more manageable; and that is intrinsically therapeutic." Thus, while many providers of intensive case management services are clinically trained mental health professionals, they typically are not the primary "treatment" provider -- other professionals are utilized when therapy is included in the intervention plan. Stroul and Friedman (1986) emphasized that the requirements for case management for children with serious problems and multiple needs are extensive and beyond the capability of clinicians who are also the primary treatment agent. They further stated that case managers who are not the primary treatment agent are in a position to more independently review progress and advocate on behalf of children and families. While they generally are not the primary treatment providers, case managers within the individualized care approach do provide high levels of support for the child and family as well as crisis intervention.

Case management for individualized care requires small caseloads because of the complexity of functions the case manager must perform. Vermont has reported that different phases of therapeutic case management require different levels of services as the child and family move through the process. The initial intake and treatment planning phases are usually the most intensive; services then generally stabilize somewhat as services and support are wrapped around the child and family in response to their needs. After a maintenance phase, the child and family finally make the transition into an inactive status. Santarcangelo (1990) reports that passage through these phases normally takes at least two to three years. The size of the caseload for therapeutic case managers would, therefore, depend on how many children were in the intensive phases and could range from a caseload of five to no more than 12 children and their families. In West Virginia, caseloads for case managers range from eight to 10.

A number of advantages have been identified in regard to using specialized case managers for individualized care. Specialized case managers can carry small caseloads and provide intensive services without the competing priorities resulting from normal agency responsibilities. Further, the case managers become experienced at working with youngsters with difficult and complex problems and skilled at managing individualized intervention plans and handling crises. In addition, they develop intimate knowledge of the resources available in the community for children and families (such as a bank of behavioral aides who can be called upon to provide support in homes, schools, and other settings) and become adept at assisting families to access these resources.

Providing Individualized Services

Since individualized services are based on the specific needs of the child and family, it follows that the process begins with an assessment and treatment planning phase. Rather than seeking a "slot" for the child in any available program, the approach involves assessing the strengths and needs of the child and family and building a program of services around them. The interagency service planning/treatment team, with leadership provided by the case manager, typically plays a central role in the assessment and planning process. Review of existing records, evaluations, and history is an important source of information for the assessment as well as information provided by the parents, child, professionals, and other key persons in the child's life.

Burchard and Clark (1990) discuss the ecological nature of the assessment conducted for the purposes of providing individualized care. Instead of the traditional emphasis on personality characteristics and child deficits, they contend that "individualized care requires a shift to a more comprehensive, multilevel approach to assessment which examines the social ecology of behavior and attempts to understand youngsters by assessing the total environment in which they function." Burchard and Clark propose four levels of assessment: analysis of the child and family's strengths; assessment of the broader social environment in which the child and family live; assessment of service needs and available community resources; and assessment, on an ongoing basis, of progress and needs. According to their framework, assessment represents a means to formulate and design specific, individualized treatment plans which better meet the needs of the child and family.

As noted, assessment and planning for individualized services use a strengths-based orientation which carefully considers and draws upon the assets of the child and family as well as their needs. Reframing how the child and family are viewed may be helpful when identifying family strengths. For example, a child who is hyperactive may also be thought of as having a high energy level and/or an exuberant, outgoing personality, characteristics which may be valued more in the adult work world than they are in the classroom. Other examples of family strengths include a mother who visits her child regularly in each of his placements; a youth who is "street smart;" a child who achieves a successful placement in a special education class; a child's budding skills in areas ranging from cooking to computers; or grandparents or other relatives who are interested in helping the family.

According to VanDenBerg (in press), needs should be defined in positive terms and might include a child's needs to express him or herself in an art form or the need to continue to excel in school as well as the need for remedial action, such as the parent's need to find employment or the child's need to stop hurting other children by learning appropriate interaction skills. The assessment and planning process for individualized care involves examining needs across all life domains. These include: 1) residential (a place to live); 2) family or surrogate family; 3) social (friends and contact with other people); 4) educational and/or vocational; 5) medical; 6) psychological/emotional; 7) legal (especially for children with juvenile justice needs); 8) safety (the need to be safe); and other specific life domain areas such as cultural/ethnic needs or community needs. VanDenBerg emphasizes that in an individualized approach, the first question asked is: "What does this youth need so that he or she can get better?" The team then proceeds to construct a plan based upon the identification of strengths and needs in all life domains. An essential aspect of the

assessment and planning process is to ascertain the child and family's own perspectives about their needs and what services and support they desire (Tannen, 1991). Friedman (1988) summarized the importance of a strengths-based, ecological assessment when he stated that only a thorough assessment, including ecologically-oriented information that focuses not only on the child's problems but on strengths and interests, will enable a decision-making team to move away from a "placement" orientation and towards a "planning" orientation and to develop an individualized intervention plan.

Developing an individualized service plan involves creative thinking from the case manager and interagency team in order to address identified needs. Individualized services typically draw upon all of the resources that the community may offer -- including services which may exist within the community's system of care as well as a limitless range of creative, nontraditional approaches which may be designed to address specific needs. As stated by MacFarquhar and Dowrick (in press), the individualized assistance approach builds services around the needs of each child and family, attempting to tailor services to each youngster and adding new or innovative services where necessary. The term "wraparound" services is derived from the notion of surrounding the child and family with a full network of services and supports, in accordance with their wishes. Tannen (1991) emphasized that one of the major benefits of individualized services is that they do not require youngsters to conform to established institutional or programmatic rules, but rather respond to the changing needs and growth of the child.

The interagency team may determine that a particular program (such as home-based services, day treatment, or therapeutic foster care) is available in the community and can be accessed to address some of the identified needs for the child and family. Beyond the existing services within the system of care, the team may identify needs for which less traditional solutions are required. Flexible funds, with few if any categorical restrictions, may be used to provide wraparound services which typically are not provided by community agencies. For example, a behavioral aide may be hired to assist at home and school to prevent the out-of-home placement of the child. A family's utility bill may be paid so that the family can be kept intact; a car may be repaired so that the mother can continue to work and get her child to needed resources. Wraparound services and supports have been provided in a wide range of areas including (Zeigler-Dendy, 1992):

- o Family Support and Sustenance - Providing emergency assistance for the child, paying for utilities, paying for repair of a car engine, paying for a telephone, paying for participation in Weight Watchers, etc.
- o Therapeutic Services - Providing individual/family/group counseling, substance abuse services, a bilingual therapist, a therapist of color, respite care in or out of home, etc.
- o School-Related Services - Providing school consultation, an academic coach, utilizing behavioral aides or classroom companions at school, paying for school insurance for classroom companion, buying a chemistry set for Christmas, etc.
- o Medical Services - Providing a needed medical evaluation, providing medical or dental care, paying for a tattoo removal, teaching sex education, teaching birth control, teaching medication management, etc.

- o Crisis Services - Hiring a family member or friend to provide crisis support, utilizing a behavioral aide in the child's home or in therapeutic foster home, teaching crisis management skills, etc.
- o Independent Living Services - Helping to locate and rent an apartment, assisting youngster to obtain Supplemental Security Income (SSI), hiring a professional roommate/mentor, providing a weekly allowance, teaching money management and budgeting, providing driving lessons, teaching meal preparation, teaching parenting skills, teaching housekeeping skills, purchasing a mobile home for a fire setter and providing 24 hour staff, etc.
- o Interpersonal and Recreational Skill Development - Hiring a friend or finding a "big brother," teaching social skills and problem solving skills, purchasing a membership in an exercise gym, a YMCA membership, horseback riding lessons, art or music lessons, summer camp registration, class trip, fishing license, bicycle, etc.
- o Vocational Services - Providing job training, teaching good work skills, providing a job coach, finding an apprenticeship, providing a mentor at the apprenticeship or other program, paying someone to hire the youth for a job, conducting a vocational skills assessment, etc.
- o Additional Reinforcers - Purchasing reinforcers including items such as a radio, make-up, clothing, punching bag, skate board, trips, dates or activities, photographs for teen magazine, etc.

Tannen (1991) warned that setbacks and crises are likely to occur during the course of implementing an individualized care plan. To prepare for this eventuality, the plan must include agreed-upon approaches for handling crises. The inherent flexibility of individualized service approaches allows support to youngsters and caregivers to be quickly increased or decreased in response to changing needs. For example, an aide may be brought into the home or classroom during a crisis or particularly difficult period. Further, based upon the underlying value of unconditional care, individualized services are provided to children and families for as long as they are needed, regardless of youngsters' behavior or the challenges and complexities presented by their needs.

Financing Individualized Services

As noted, the availability of flexible funds to implement imaginative and resourceful intervention plans is a critical element of individualized care. While expenditures of flexible funds may appear unusual, it is this ability that allows a package of services and supports to be tailored to the specific needs of the child and family. Olson, Whitbeck, and Robinson (1991) stressed that funding which is not preallocated to existing component services allows teams the freedom to create and implement a tailored program that can be responsive to the unique and changing needs of the child.

While creating flexible funding mechanisms is particularly challenging, Tannen (1991) emphasized that in order to provide creative, individualized services, expenditures cannot be expected to fit into current agency line item categories. In fact, categorical funding

restrictions present a major barrier to the delivery of individualized services. Most state and federal funds have categorical restrictions which limit the ways in which the funds may be spent. For example, some state legislatures or agencies establish categorical funding streams which may be spent only on specific types of services, such as residential treatment; funds cannot be spent on services to prevent removing a child from his or her home. Flexible funds, with few if any categorical restrictions, are available in a limited (but steadily increasing) number of states and communities.

Several states have initiated policy changes at the state level which have eliminated some categorical funding restrictions and paved the way for the creation of flexible funds for individualized care. In West Virginia, for example, child welfare officials eliminated categorical funding restrictions by developing a policy which allows expenditure of residential funds for the development of services in the local community. If a child is placed in a residential treatment facility at a cost of \$75,000, the local interagency committee can spend up to that amount for delivery of individualized services in the local community. State policy currently is being formulated regarding the utilization of any uncommitted funds returned to the state. Areas of the state which have maintained low out-of-home placement rates will be given priority to access these funds. Additionally, a community may apply for funding from this "savings pool" to develop a new service or to fund an individualized service plan for a child for whom no other source of funding is available. In Iowa, an initiative to decategorize the funding for services to youngsters and families in order to provide more individualized and responsive care has been implemented in four counties. These types of policy changes represent clear shifts in incentives for local areas to serve youngsters within the community and to use individualized service approaches.

In addition to redirecting funds from residential or out-of-state care to community-based, individualized care, a number of states and communities are creating pools of blended funds from the various child-serving agencies as a mechanism to provide flexible funding. A legal agreement signed by the child-serving agencies in Stark County, Ohio blends \$700,000 a year from multiple agencies which is used to fund individualized service plans for multineed youngsters and their families.

In some states and communities, legislators and administrators remain suspicious of flexible funding approaches. The fear that funds will be squandered and personnel will not be held accountable forms the basis for this attitude. Accountability mechanisms built into flexible funding procedures help to alleviate these concerns. Although reliable and systematic accountability procedures are essential, guidelines for administering flexible funds should be kept as simple as possible. Cumbersome administrative procedures hamper the ability of case managers to implement individualized care plans and to adjust services and supports promptly in response to changing needs. Additionally, rapid access to flexible funds is critical. When a family is in crisis, funds may be needed immediately to prevent escalation of the crisis and removal of the child from the home.

While flexible funds have been called the "linchpin" of individualized care, many states have developed a wide array of Medicaid-billable services which allow for the provision of innovative and nontraditional services and supports. Recent revisions to the Medicaid EPSDT (Early Periodic Screening, Diagnosis, and Treatment) program offer one mechanism for expanding services to children with serious emotional problems, allowing for Medicaid

reimbursement of all service needs identified during EPSDT screening. The Robert Wood Johnson Foundation demonstration site in Pennsylvania developed a range of services for which Medicaid reimbursement can be provided under the EPSDT program including services such as after-school programs, prevocational rehabilitation, weekend and holiday therapeutic services, mobile crisis services, short-term intensive staff supports, in-home treatment, on-site school and work treatment services, and others. A detailed individualized service plan is created which forms the basis for service delivery and Medicaid reimbursement.

Research on the cost-effectiveness of individualized services is needed. Reports from various states and communities indicate that, apparently, intensive, individualized services are less costly than institutional alternatives. Dowrick (1988) reported that the costs of out-of-state placements for youngsters in the Alaska Youth Initiative averaged \$72,000 per year; the same children were cared for in state at an average cost of \$47,000 per year. Burchard and Clark (1990) stated that in addition to the savings, it is believed that better services are being provided through the initiative. They contend that the cost-effectiveness of individualized care in the Alaska Youth Initiative, and other situations in which children are returned from residential placements, is demonstrated by using each child and his or her own control and showing that youngsters display good adjustment through less costly and less restrictive services. They acknowledge, however, that it is more difficult to demonstrate cost-effectiveness in situations in which individualized care is used to prevent residential treatment placement rather than to return youngsters from placements. In many cases, youngsters who have not as yet been placed in residential treatment are receiving few services prior to the initiation of individualized care, and as a result, costs increase as individualized service plans are implemented. Comparison groups are needed to demonstrate cost-effectiveness across broader client populations. While sufficient research to substantiate cost-effectiveness has not yet been completed, it appears that the individualized care approach potentially can effectively serve some of the most difficult-to-serve youngsters at costs which compare favorably to most residential treatment or hospital settings.

III. IMPLEMENTATION EXAMPLES

The Alaska Youth Initiative is a prime example of a systematic approach for utilizing individualized services to meeting the needs of children and adolescents with severe emotional disturbances. The Alaska Youth Initiative is described below to demonstrate the application of the principles and process of individualized services. The individualized services implemented in Vermont also are described to amplify the use of this approach in other settings and to demonstrate how individualized services can be integrated within comprehensive, community-based systems of care.

Alaska Youth Initiative

Alaska is a unique service delivery environment from many standpoints: its geographical mass is equal to 20 percent of the combined area of the other 49 states and is over twice the size of the next largest state. When superimposed over the contiguous 48 states, the breadth of Alaska reaches from coast to coast and in height from Mexico to Canada. Many of the communities are accessible only by air. Alaska also has one of the smallest state populations

and a population density which is one-fifth of that in the next more populous state. However, it is similar to many rural states as most of the population is concentrated in a few centers. Most of the state's resources are available only in the one large city, Anchorage. The second largest city, Fairbanks, is eight hours away from Anchorage by car and an hour by air. The third largest city, Juneau, is land-locked and is two hours by air from either Anchorage or Seattle, Washington. Within this context of difficult geography, low population density, and a dearth of services even in the most populous centers, the care of children and adolescents with severe emotional disturbance has traditionally been difficult. As a result, many youngsters were sent to out-of-state facilities for care. In addition, many children were cared for in the major in-state centers far from their home communities, the equivalent to being out of state.

The Alaska Youth Initiative (AYI) is a collaborative program of the state-level mental health, social services, and special education agencies. It is housed in the Alaska Division of Mental Health and Developmental Disabilities and currently is funded by special allocations from the mental health, child welfare, and special education budgets. An Interdepartmental Team (IDT) made up of representatives from each of the collaborating agencies manages the program and makes policy level decisions; the IDT also determines eligibility for the program. AYI is run by a state-level coordinator hired by Division of Mental Health and Developmental Disabilities and uses local coordinators, primarily in hub communities, who are responsible for coordinating services for individual youngsters. Currently, there are 12 local coordinators in key locations around the state.

The original target population for AYI was composed of emotionally disturbed youth placed out of state. In 1985, this population numbered close to 40, at an average cost of over \$70,000 per child. Shortly after its inception, the program was put under some pressure to expand its population to include emotionally disturbed youth who were at high risk for placement. Today the broad target population for AYI is "children and youth who are severely emotionally disturbed and/or severely mentally ill." This population is then prioritized by a number of factors which include being at risk for out-of-state placement and having exhausted the local service system.

More specifically, the criteria for inclusion in the AYI population are:

- 1) The youth has multiple and enduring needs which are generally going unmet.
- 2) An inability of the local service system to adequately serve the youth in spite of collaborative attempts.
- 3) As a result of the above two conditions, the youth is now at risk for being sent out of state (or out of region) to an unduly restrictive placement.

Referrals are generated by local interagency teams who feel that a youth fits the AYI criteria. A local referring team must, at minimum, include representatives from the school district and mental health arena, and, in custody cases, the child welfare agency. The Alaska Psychiatric Institute, the state hospital, can make direct referrals to AYI but is encouraged to utilize a broader team when possible.

Information about the youth is reviewed by the IDT which determines the acceptance for services under AYI. Eligibility is determined through a majority vote of the IDT members. If a youth is not accepted, the IDT may suggest other community, or even out-of-community, options judged to be more appropriate. There is a rarely used process through which the directors of the involved state agencies may hear appeals of decisions made relative to AYI eligibility.

Upon acceptance, the case is assigned by the State AYI Coordinator to a well-trained local AYI coordinator whose first job is the creation of a core services team. This team, which is most often an extension of the referring team, is the group that will work together with the youth and his or her family to create the most appropriate service package. To create the team, the coordinator identifies those community individuals who have been influential in the youth's life. Of prime importance on these teams are parents who act as both key informants and resources; the youth also is included when his or her age and maturity make it appropriate. The team also includes mental health professionals who have worked with the youth and family, as well as attorneys, relatives, case workers, and teachers. Other participants could be ministers, youth or recreation workers, or friends. The local AYI coordinator chairs the core services team; the State AYI Coordinator is available to provide support, guidance, and technical assistance as needed.

The team first conducts an assessment of the strengths and needs of the youth and his or her family. Since AYI constructs an individualized approach, the assessment becomes a vital exercise around which the entire treatment plan is created. Unlike traditional mental health assessments that primarily focus on psychopathology, AYI assessments explore a full range of basic needs. These include residential, family, social/recreational, psychological, educational, vocational, medical, and legal needs. By examining a full range of needs, the assessment discovers areas in which the youth and family have assets to build on as well as finding liability areas that need to be supported. The team uses personal information from the participants as well as available tests and reports to make determinations in each of these need areas. An attempt is made to determine needs through a discussion process without regard to which interventions will be necessary; in this way the team is less likely to determine need on the basis of which services are available and more likely to develop a more objective view. AYI has tried to use more formal needs assessment tools, but none has proven useful within this setting.

The assessment feeds directly into the process of service planning; in many instances the processes become intertwined. Service planning involves the development of a treatment plan which is based on a major premise of AYI -- that care is unconditional. Once the IDT accepts the youth, both the local AYI coordinator and the local core services team accept that there is the a no-reject policy and that they must come up with a workable service plan for the youth and family. They also understand that there is a no-eject policy, so they must stay with the youth and family adjusting the service plan for as long as necessary. This policy is made workable by the flexibility which is given to the local team to create an innovative service approach. The team also understands that many of the youngsters who are accepted by AYI are there because traditional service options and placements have failed and that they must do something different if the youth is to succeed. They also know that these are the most troubled youth and that it will be difficult to help them to succeed.

The service plan for each youngster served by AYI is unique. The core services team brainstorms to fill any gaps that the youth and family have in meeting those needs identified through the assessment process. Since the funding for each youth is entirely flexible, any community resource can be used and paid for regardless of its usual funding sources and its price. Stories of extremely unusual uses of resources by AYI abound; they include buying "friends," placement with a fisherman for a youth who wanted to be a fisherman, and purchasing a snowmobile. While the team may choose to use existing services in the community, certain necessary services often are not available, and when they are, they may not exactly meet the individualized needs of the youth. However, most treatment plans include some traditional services such as therapy, special education classes, day treatment, and family support. An individualized education program (IEP) is introduced as part of the treatment plan when appropriate.

In 1988, 20 percent of AYI youth were placed in their original homes. When placement at home is not possible, alternatives are used. The most flexible, and therefore most commonly used, placement is therapeutic foster care, called family treatment homes by AYI. Forty percent of the youngsters served by AYI were placed in these homes in 1988. While there is no formal therapeutic foster care program, the principles of this form of intervention are used. Foster parents are chosen based on their unique qualities to fit with the needs of the youth and are given ongoing support and training by the local AYI coordinator. For example, the fisherman, mentioned above, was used as a "foster parent". Other forms of residential care have included teaching family homes which offer therapeutic group living within a structured family setting (16 percent) and more traditional group homes and other residential programs (11 percent), where these more formal programs meet the needs of the youth and can be flexible enough to accept the principles of AYI. Older youth may be placed in supervised apartments and other independent living situations (11 percent). When AYI youth are hospitalized or enter other more restrictive settings, it is assumed that these will be short-term, that the treatment team staff will remain involved, and that the youth will return to the community and/or less restrictive care as soon as possible. AYI has demonstrated that it is possible to provide extremely intensive intervention in normative environments.

AYI relies heavily on the use of aides to work with youth in their families, alternative placements, regular school or special education programs, and recreation settings. These aides tend to be individuals with a minimum of training but with a good sense of how to deal with youth and how to help control them when they are out of control. The aides have flexible schedules; at times they may be needed full-time, in shifts, or on call. The aides offer the extra support needed by a family, foster family or program in order to be able to keep the youth. With the judicious use of aides, almost any community setting can be as supportive as an intensive residential placement.

Because the cities and regions in Alaska are so different, the types of treatment plans and the modes of service delivery vary considerably across the state. For example, Anchorage has many services available enabling AYI staff to play a more coordinating role, with services being delivered by community resources. Bethel, on the other hand, is a small community with many fewer service resources, necessitating that AYI staff provide more direct services to children and their families.

Once the core services team has developed a way of reasonably meeting the needs of the youth, the cost of the total plan is determined and projected on an annual basis. The completed plan, specifying roles and responsibilities, and the associated budget are then transmitted to the State AYI Coordinator for review. Modifications, if required, are negotiated between the state and local coordinators. The plan is then presented to the IDT for final approval. When approved, the plan is returned to the local team for implementation.

The interventions are monitored by the local AYI coordinator who also sends progress reports and evaluation data to the State AYI Coordinator on a monthly basis. The core services team meets as necessary to monitor and modify the service plan; progress is regularly reviewed on a quarterly basis.

Transition between services and placements is seen as an important part of the intervention within AYI. The local AYI coordinator who is working with the youth is responsible for making sure that there are links between programs, and that before and after the youth makes a move, the youth will have a chance to experience the new service delivery setting and will be able to give up connection with the old setting in a way that is appropriate for that youth. If a youth is hospitalized or placed in a residential center, the coordinator is responsible for continuing to work with the youth and the staff during the placement and for planning and implementing with the staff a smooth transition back to community services. When a youth is doing well enough to be discharged from AYI, there is equal concern about transition, and the local AYI coordinator and core services team assume the responsibility for making the shift out of AYI smooth and appropriate to the youth's needs.

Financing of the treatment plan is a major aspect of AYI. The concept of individualized services requires flexible funding, which is best created through the pooling of funds from various sources to meet the needs represented in individual treatment plans. Originally, the funds for AYI came directly from those monies used by the child welfare and special education agencies to support youngsters in residential placements. These funds were pooled and placed under the control of the IDT. During the first years of the program, there was a legislative appropriation of mental health funds to support the growth of AYI. Currently, the three major agencies (mental health, child welfare, and special education) pool monies to support youngsters to be served under AYI. The core services teams each develop service plans for the specific youngsters for whom they have responsibility and request funding from the IDT. The IDT in turn, gives the local coordinator the funds to activate the treatment plan. The core services team can use those funds in any way that makes sense within the treatment plan and can appeal for more funds if the treatment plan changes in a way that would require higher costs.

Flexible funding, while theoretically pleasing, can be a bureaucratic nightmare. Therefore, AYI was constructed so that, even though extremely flexible in the use of funds, it would be extremely thorough in the tracking of funds. Such easily available amounts of money which often are used for institutionally unnatural things (such as a snowmobile) must be accounted for in a very precise way. Every expenditure must be related to the treatment plan and be well justified within that plan. In this way, extraordinary expenses can be successfully defended. An AYI Project Assistant, who reports to the State AYI Coordinator, is responsible for monitoring and tracking expenditures for accountability purposes. In addition to

monitoring budgets and expenditures for each youngster served, the assistant works closely with state fiscal staff.

Along with accountability, such a new and innovative approach as AYI requires a well-done evaluation in order to prove its efficacy. Initially, the program developed a system for the statewide monitoring of client outcome data that the IDT felt were vital to the success of the program and adequately reflected the goals. These measures include:

- o Number of days in an inpatient psychiatric or locked juvenile detention setting
- o Amount of drug and alcohol use or possession
- o Incidence of runaway episodes
- o Number of days in school
- o Amount of assaultive behavior
- o Amount of property damage
- o Number of police incident reports
- o Degree of voluntary medication compliance

Other tracked events were:

- o Number of suicide attempts
- o Number of days in the community
- o Amount of time in the family or a family-like setting and the amount of parental involvement
- o Number of placements

These are easily measurable events that are directly related to the goals of AYI; each of these outcomes has a written definition.

A number of features or strategies have proven to be vital aspects of AYI:

- o **Working with the Most Troubled Youth** - AYI was conceptualized and designed to offer the level of service needed by the most troubled children and youth at a level equivalent to the services offered in most hospitals and intensive residential treatment centers. Therefore, in order to adequately test the approach, the program had to actually work with those children and youth who were considered the most difficult to serve. In fact, as the program began, this aspect was tested, as AYI was presented with two youngsters whose behavior was so disturbed that they were being ejected from their out-of-state placements. Struggling with the application of individualized care principles to a difficult-to-serve population helped to define the process and procedures necessary to use this approach successfully. If the approach had been "tested" on less troubled youngsters, it would have been difficult to later adapt the model to the toughest youth.
- o **Using Failure as a Learning Experience** - When one works with the most troubled youth, it stands to reason that occasionally a treatment plan will fail. AYI was conceived and implemented with this understanding. Further, when a program is built on the principle of unconditional care, each of these failures becomes, of necessity, a learning experience through which staff reflect on what they did wrong,

what incorrect assumptions were made, and how to proceed from the point of failure toward a successful intervention. In many traditional programs, failure most often leads to referral to a new program which begins working with the youth out of the context of the prior failures. As a result, new programs often repeat the unsuccessful patterns of the old, and lead to inevitable failure. This creates a pattern of a series of failed service attempts, a pattern which may continue until the youth is institutionalized or until he or she ages out of the system. With a wraparound service delivery approach, the lessons of failed placements or other unsuccessful interventions are used in the development of the next steps. As a result, the number of failed interventions appears to decrease for youth in AYI.

- o **Establishing a Strong Political Base** - Individualized, wraparound services are a new modality, and as such are not generally accepted as the "usual" care. While new services typically are placed under increased scrutiny, the probability of intense scrutiny is even greater when a program focuses on the most troubled youth and expects occasional failure. Often, any degree of failure dooms a new service politically, even if the target population is a difficult one. AYI was able to grow in spite of this risk because the developers understood these political realities and created a strong base of support among key politicians and policy makers who believed in the concepts of the program and its anticipated outcomes and who understood the risk and growth opportunities presented by occasional failure. This political base was essential in helping AYI move through its initial stages, and was useful in getting full funding of the project.
- o **Providing Unconditional Care and Strengths/Needs-Based Assessments** - The basic tenets of unconditional care also are major features of AYI. Having a no-reject/no eject policy forces the program to plan services in a way that gives providers a realistic chance of keeping the unconditional care promise. Assessments of both strengths and needs across the full range of basic life domains enhance the likelihood of meeting the child and family's needs and of building on their unique strengths, thereby providing effective care. This type of assessment recognizes assets as well as liabilities; identified strengths are then used by the team in creating a balanced intervention plan.
- o **Flexible Funding** - In order to create interventions that meet the unique needs of any youth and family, there must be funding sources that allow for their support. In general, traditional funding sources are extremely narrow in their focus; they encourage the exclusive funding of program components within a system of care. Within AYI, funding of treatment plans comes from pooled monies that have no restrictions, other than to meet the needs as stated in the treatment plan. Wraparound service technologies require this type of flexible funds in addition to funding for formal service programs. Alaska provides flexible funds through special allocations from each of the involved agencies.
- o **Accountability** - In order for funding to be flexible, and often to purchase extremely nontraditional services, AYI requires that each dollar spent be accounted for and be related directly to a treatment plan. The program refers to a "paper trail" which must follow every dollar spent for an AYI youth. In this way, unusual expenditures of

funds for rent, buying friends, or special items such as a snowmobile can be justified to even the most skeptical observer as part of the intervention.

- o **Evaluation** - Innovation breeds skepticism, and the developers of AYI feel that the only way to overcome that skepticism is to ensure that solid evaluation results support the program. Based on the outcome measures previously described, the program has been shown to be effective in meeting its goals relating to both returning youth to the state and community, but also to decreasing the troubled behaviors that the youth exhibit. The success demonstrated by evaluation has served to silence the detractors of this innovative approach.

It was reported that the philosophy and process used by AYI is beginning to be applied more broadly in Alaska (Fritchette, 1992). As a result of their experience with individualized services provided through AYI, community mental health centers and other child-serving agencies are beginning to adopt the philosophy and process of individualized care in their communities. This process has been advanced by new Medicaid and EPSDT regulations in Alaska which require the use of interagency teams and individualized approaches for youngsters with serious emotional disturbances. In addition to the spread of the individualized approach among more traditional agencies in the state, villages ranging in size from 300 to 4,000 residents with few, if any, formal services are learning to use personal and community resources to support youngsters and keep them in the community. Education and training regarding interagency collaboration and providing wraparound services have helped to promote both acceptance and experimentation with the individualized care approach beyond the confines of the services and funds provided through AYI.

The Vermont Experience

The Vermont approach, while built on the same basic principles of individualized care as AYI, differs in several respects and presents an alternative model. From a demographic and geographic point of view, with the exception of size and the presence of Alaska's large native Alaskan population, Vermont does not differ significantly from Alaska. Vermont is an extremely rural state, it has no large urban center, and its largest city has a population of less than 40,000. Vermont has a system of community mental health centers that covers the state; however, as in many localities, the centers' ability to serve children and adolescents has historically been limited.

Vermont's wraparound service capacity is centered on the concept of therapeutic case management. Vermont has created a continuum of care for a broad population of children and adolescents with severe emotional disturbance. The therapeutic case management program is one service within that continuum, available for the most needy members of the target population as determined by a local committee. The most troubled and most at-risk children and youth are offered individualized, intensive services coordinated and directed by a therapeutic case manager along with a treatment team. This model places greater emphasis on the role of the case manager who coordinates local component services than does AYI which focuses more heavily on the local treatment team for coordination and for which appropriate local services often are not available. In Vermont, case management/wraparound services are delivered in the context of a total system of care which offers a broad continuum of services to be used by any individual in need, including, when appropriate, those who are

eligible for individualized services. This approach contrasts with AYI which has not emphasized the development of a full system of care in all areas of the state.

Vermont has used its Child and Adolescent Service System Program (CASSP) to create a local capacity to respond to children and adolescents with severe emotional disturbance and their families. Following a five-year federal CASSP grant, the state created and passed legislation that codifies the system of care for children and adolescents with severe emotional disturbance. This mandate created a state definition of the population that is to be used on an interagency basis. In addition, two state-level structures were created to oversee services to the target population. The first of these is a Governor's Advisory Board made up of five parents, five advocates, and five professionals who are responsible for making broad policy recommendations to the heads of the major child-serving agencies including the commissioners of education, mental health and mental retardation, and social rehabilitation services. The second is a State Interagency Team, which functions to: 1) implement state policy for children and adolescents with severe emotional problems, 2) resolve local problems in meeting the needs of the target population, and 3) monitor the state's wraparound service programs. This team consists of representatives of the state agencies mentioned above and a parent of the child who is experiencing severe emotional problems.

The primary mandate in the legislation is to create a statewide system of local interagency teams (LITs), one in each of the state's 12 social service districts. These teams are made up of local agency and parent representatives and are responsible for working together to deliver services to multineed, cross-agency youth. Local treatment teams, created to develop an individualized services plan for each youngster, can refer children and adolescents and their families to the LIT for help in resolving problems of access to adequate service delivery. For those children and adolescents who meet the state definition, the LIT works with local treatment teams to develop individualized service plans. Children and adolescents who are at the highest level of risk for removal from their home or community, or who are already in out-of-state placements, can be accepted by the LIT into the individualized service program which focuses on the provision of therapeutic case management and related wraparound services.

At the same time, the state has been implementing an initiative that will ultimately extend the full continuum of services of the system of care into all areas of the state. These services include intensive home-based services, therapeutic foster care, community-based residential alternatives, crisis stabilization, parent support groups, respite care, and special education programs, in addition to the therapeutic case management. The network of community mental health centers has been the focal point for the development of these service capacities.

In 1989, Vermont applied for and received a grant from the Robert Wood Johnson Foundation (RWJ) Mental Health Services Program for Youth in order to help support the development of the full continuum of services and the wraparound capability. This grant, called New Directions, is directed toward implementing this statewide comprehensive community-based system of care through the support of interagency collaboration, development of new service capacities, and the restructuring of the financing mechanisms for the funding of the system.

The children and families receiving individualized services in the Vermont system are described by the state officials as those children and adolescents who have the most severe

emotional disturbances and the most challenging family circumstances, which place them at high risk for removal from their homes and communities (the formal definition is very similar to the AYI definition). By the second year of the Vermont project, 176 children and youth meeting the definition of the target population had been served in some of the services within the system of care, and 29 had been offered individualized services through the therapeutic case management part of the program.

While AYI initially focused on those children placed out-of-state and later dealt with youth at risk, Vermont started with a broader population. The program evolved from Project Wraparound which was created with a mandate to prevent out-of-home placement; returning children from out of state was a secondary aspect of the mission. While this difference between the AYI and Vermont approaches may seem merely semantic, it should be noted that preventing placement and returning from a long-term placement require very different approaches, and that the shift from one to the other is not always a simple process. Further, it is easier to demonstrate the savings for a youth returned home from an expensive placement than to prove that high-cost wraparound treatment actually prevented a placement, especially if other youth are still being placed out of home and state.

The process for delivering individualized services in Vermont is very similar to that used in AYI. Children and adolescents are referred to the therapeutic case management program by the LIT. When a child is accepted, a case manager is assigned and proceeds to review the records and meet the family and other individuals who impact on the child. The next step is the development of a treatment team, the composition of which is identical to the AYI core services team. The team's first duty is the development of a service plan. This plan is based on a thorough assessment across a broad range of life dimensions. While these assessment dimensions are similar to AYI's, the categories have subtle differences. They include residential, therapeutic/behavioral, educational/vocational, social/recreational, medical/psychiatric, safety/crisis plan, legal, and other. The process for conducting this assessment appears virtually identical to AYI's, and a similar strengths-based orientation is used to balance the identification of problems and needs.

Once the service plan is developed, the therapeutic case manager assumes a special role. In Vermont's plan for implementation of therapeutic case management (Santarcangelo, 1990), the role of the therapeutic case manager is described as using natural supports in the community and/or organizing services provided by agencies. "The therapeutic case manager acts as the person accountable for coordinating and ensuring appropriate and timely services for children/adolescents and their families. They are responsible for brokering services for individuals, and advocating on the child's behalf across service systems. Therapeutic case managers ensure that adequate service plans are developed and implemented and provide ongoing review of the child's progress and program outcomes."

Many of these roles are handled by the local AYI coordinator in Alaska. In Vermont, they are handled by specific workers with both a master's degree in a human service field and a minimum of two year's experience with children and adolescents with severe emotional disturbance. With case loads of four to 12, the therapeutic case manager spends an average of seven to ten hours a week with each family performing three basic functions: advocacy, coordination, and education. In addition, the therapeutic case manager also is involved in assessment, planning, linking, monitoring, and evaluation.

Unlike Alaska where many communities do not have an array of services, individualized care plans in Vermont more than likely include component services that are part of the continuum of care. Wraparound services work in these settings to help support both families and service providers to be able to meet the child's or adolescent's need in a community-based setting, including the home. Eighty percent of those in the program live in therapeutic foster care or in supervised independent living, and the other 20 percent are at home or in other normalized home settings.

An important aspect of the Vermont program is the special focus on crisis stabilization and respite. This emphasis is based on the recognition that a child or adolescent who has an emotional disorder will, at some time, have a crisis. At the beginning of the treatment planning process, the types of crises which are most likely to occur are anticipated, and a plan to respond is developed in advance. The RWJ grant is being used, in part, to support the development of crisis stabilization programs provided by the community mental health centers. Similarly, both the child and family's need for respite is anticipated, and respite plans are developed that allow the parent and/or child to have a break. It should be noted that the statewide availability of respite services has been enhanced by the fact that Vermont has received two successive respite care grants from the U.S. Department of Health and Human Services specifically to meet the needs of children and adolescents with severe emotional disturbances and their families.

Unlike AYI which has pooled funds to support the individualized services for eligible youth, Vermont has struggled to create a funding package, utilizing existing federal and state funding streams, that meets the needs of each of the youngsters involved. For those children and adolescents who qualify for medical assistance, usually by being a ward of the state, this funding has been aided by Vermont's history involving the flexible use of Medicaid funds. For children and adolescents in state care, the primary source of funds are Medicaid clinic and rehabilitative services and Title IV-E. Using a Medicaid Home and Community-Based Waiver, these federal funds can be used to fund most of the services in any child's treatment plan and are used to support children in their families' custody as well as those youngsters in state custody. The costs of residential services can be offset with Title IV-E monies. The state match for these funds comes from reallocation of state mental health, child welfare, and education monies previously spent on other placements along with funds from the RWJ grant. While this works well for the children and adolescents in state custody or otherwise eligible for public funds, funding of individualized treatment plans for non-public fund eligible youth remains problematic. Further, the Medicaid waiver can serve a maximum of 116 children per year by federal mandate. To expand services to additional children, the state is attempting to recapture more of the monies previously spent on expensive out-of-state placements and to develop a fund from private and federal sources.

For each child and adolescent, an individualized funding plan must be developed, juggling all of the possible sources. While this process appears cumbersome, it makes the best use of existing financing opportunities and the program is not beholden to a politically controlled appropriation as in AYI. The state is attempting to develop a less complex funding scheme, utilizing all available funding sources.

As in AYI, the Vermont approach requires the availability of flexible funds as a major vehicle for providing individualized services. In AYI, all of the funding is flexible, and flexible funds

for nontraditional services are taken from the same pool of funds. In Vermont, special steps have to be taken to create a pool of flexible funds for nontraditional services that cannot be supported by any other funding source. The agencies involved in the effort have worked together to create a fund of flexible dollars to pay for those services that are not covered by any agency's funding patterns.

Vermont and Alaska have worked together on the concept of proactive client tracking. AYI uses a proactive client tracking format in which the team decides which behaviors and outcomes key informants will periodically report on. In contrast, Vermont uses a standardized format where a series of indicators (both positive and negative) are tracked by the primary caretaker on a daily basis using a computer input form. Each of these behaviors is clearly defined and the reporter notes if that indicator has been present at any time that day. They are:

o Physical Aggression	o Suicide Attempt
o Property Damage	o Fire Setting
o Theft	o Strange Behavior
o Runaway	o Self-Confidence
o Alcohol/Drug Use	o Compliance
o Sexual Acting Out	o Peer Interactions
o Extreme Verbal Abuse	o School Attendance
o Sad	o Parent Contact
o Anxious	o Vocational Involvement
o Self-Injury	o Police Contact
o Life Threat	o Positive (defined daily)
o Sexual Abuse/Assault	

This process is used to monitor individual children and youth, as well as to establish a framework for understanding how the approach as a whole is working.

Vermont has been involved in the design of new methodologies for the study of individualized services approaches. While still under development, the methodology has a four-component evaluation system evolving in collaboration with the University of Vermont. The four components include the :

- o Daily Adjustment Component, which is the daily proactive client tracking data described above;
- o Bi-annual Adjustment Component, which is performed every six months using the Child, Teacher, and Youth Self-Report Checklists designed by Achenbach and Edelbrock (1983);
- o Service Tracking Component, which provides weekly information regarding the services provided to the child or adolescent; and,
- o Consumer Satisfaction Component, which includes client satisfaction questionnaires for children, adolescents, and parents to be used every six months.

Each of these evaluation factors will be used to follow the progress of each individual, youngster, and when aggregated, to follow the progress of the entire individualized care effort.

A number of vital features distinguish the Vermont approach. Similar to AYI, the Vermont approach is based on the premises of unconditional care, ecological assessment, use of flexible funds, and evaluation. The Vermont approach demonstrates several other factors which contribute to its success:

- o **Crisis Anticipation and Management** - The program operates with the understanding that children and adolescents with severe disturbances are likely to experience periodic crises. In many traditional service systems, crises lead to failed placements and program plans. Each Vermont intervention plan anticipates the types of crises that an individual child or adolescent may experience and develops a plan specifying how the treatment team and the family will respond. In this way, the many adverse effects of crises can be minimized and the commitment to unconditional care is operationalized in a very practical way. For this reason, Vermont is developing crisis stabilization programs across the state.
- o **Legislation** - Vermont has used legislation to codify the manner in which the system of care for children and adolescents with severe emotional disturbance will be viewed and developed. This legislation has had the effect of taking ideas that have been developed and tested and making them the state standard. State agencies have developed programs consistent with the philosophy of individualized care. This has resulted from the state's long-standing commitment to interagency collaboration as well as its commitment to a set of principles for a system of care which stresses individualized, child-centered, and family-focused service delivery. Thus, the principles of individualizing services are being spread and practiced across the whole system.
- o **System of Care** - The Vermont approach relies on the presence of a strong system of care that provides several vital components in each service area of the state. These include intensive home-based services, therapeutic foster care, crisis stabilization, special education, parent support groups, respite care, supervised independent living, community residential services, and therapeutic case management. All of these services are used as part of individualized service plans.
- o **Use of Current Funding Mechanisms** - Since Vermont has no mechanism for pooling monies to be used flexibly to fund individualized service plans, most of the services must be funded through existing state and federal funding streams. While this may be easier in Vermont because the state has learned to use Medicaid in innovative ways through its Home and Community-Based Waiver, sophistication is still required for the successful application and blending of all appropriate and available funding mechanisms. Vermont has chosen this approach rather than struggle with the creation of a large interagency pool of funds as has AYI. Ultimately, application of existing mechanisms can lead to the restructuring of those mechanisms to better meet the needs of the system of care. Further, the use of current funding

streams links the wraparound program to the rest of the service system, making it easier to apply individualized service concepts across the entire system of care.

IV. EVALUATION OF INDIVIDUALIZED SERVICES

Because individualized services are viewed as a new modality, it is essential to evaluate this approach in order to substantiate its effectiveness. Evaluative data can potentially strengthen the political base of support for these services as well as help to understand the benefits of this approach for the child, family, and community. Engel and Lubrecht (1992) surveyed 24 individualized care programs across the nation and found that all were engaged in studying their programs in some way, most using multiple measures. Most prominent among the areas of study were: 1) cost comparison analysis, 2) placement prevention data, 3) intervention efficacy (often through client tracking), 4) family satisfaction, and 5) interagency collaboration.

As with the services, the evaluation of outcome is often individualized to fit with the needs of the child and family. For example, AYT's proactive tracking system periodically asks key informants to comment on the progress of the client using those factors identified in the client's assessment and reflected in the treatment plan. Vermont's client tracking system, described above, includes the formal tracking of standardized behaviors on a daily basis. These specific tracking mechanisms are useful in evaluating the individual progress of each child or adolescent as well as the overall success of the program.

In addition, more standardized evaluation tools are used to track the progress of youngsters receiving individualized care. Tools such as the Child Behavior Checklist (CBCL), along with accompanying Teacher and Youth Self-Report Checklists (Achenbach & Edelbrock, 1983), are used to track progress and to assess how clients are behaving against national norms. Vermont uses these tools every six months to track each child and adolescent's "adjustment."

Client satisfaction, from the perspective of both the youth and family, is an important measure of how well a system of care is achieving its goals, particularly for a system of care which is designed to meet individual needs. Vermont is developing a consumer satisfaction questionnaire which will be administered every six months to parents, children, and adolescents. Other programs have developed their own process for measuring how well the service system is meeting the perceived needs of the client and family.

Since each intervention plan used in a wraparound program is unique, the service package for each child or adolescent and family consists of a different array of services. In order to attempt to understand the relationship between the array of services offered and the eventual outcomes for the child or adolescent, it is vital that the exact services that are delivered be closely tracked. This becomes an extremely complex task with individualized services for two reasons. First, within this concept of service delivery, the definition of what comprises a service is extremely broad. This is exemplified by situations in which having a friend is considered a service, or the provision of an aide is equal to psychotherapy in treatment plan importance. Secondly, the service array changes frequently in accordance with the changing needs of the child or adolescent.

Several approaches have been used to relate services to outcome. First, the level of services has been quantified in terms of the relative degree of restrictiveness. The most notable example of this is the Restrictiveness of Living Environments Scale (ROLES) developed by Hawkins and colleagues (1992). In this scale, each type of setting receives a restrictiveness score, with living at home being the least restrictive and hospitalization or locked institution being the highest. These scores can be compared to behavioral outcomes and/or used as outcome measures themselves. A second approach to service tracking is exemplified by CareTrack, a data system developed by the Robert Wood Johnson Foundation Mental Health Services Program for Youth, which systematically follows the array of services related to a treatment plan, the specific goals of that service, the number of service units delivered, and the progress toward the specific goal. While a complex computer program is still in its final stages of development and testing, CareTrack has the potential to be a powerful tool in the understanding of how individual services within an array of services relate to the progress that the recipient demonstrates.

At the University of Vermont, Burchard and his colleagues have been developing a research approach to evaluating services, including individualized care. Building from the success of their proactive client tracking concepts, they have developed a scheme for tracking children and adolescents through their life histories in a number of domains which include residential, behavioral, services, life events, family, services, and costs. This approach, called a multiaxial timeline, combines many of the aspects of the evaluation of individualized services. The University of Vermont team is currently working on developing the multiaxial timeline into a clinical and evaluation tool rather than a research instrument.

Few evaluation results on individualized services have been published to date, primarily because most individualized service efforts have been in existence for relatively short periods of time. Evaluation data from programs that have been operating the longest are encouraging. VanDenBerg (in press) reports that, after its first five years of operation, AYI was extremely successful in meeting its two major program goals. The first of these was to limit further inappropriate out-of-state placements. This goal was achieved; since 1986, only two youths have been sent out of state for treatment out of the 117 youngsters served by AYI. Both of these youths were so placed in the first two years of AYI and have since been returned to Alaska. The second goal was to return youth who were already in out-of-state facilities. This goal also has been achieved; as of 1991, only one youngster remained in an out-of-state placement, and no youth who was returned to Alaska through AYI has had to return to an out-of-state placement.

In 1990, the state and local AYI coordinators were asked to assign ratings to all AYI youth who had been served for at least six months (a total of 81 youngsters). The rating process was intended to obtain a global measure of the perceived successfulness of the individualized services approach for each youngster. Ratings indicated that 67 percent of the cases were perceived as having a successful outcome; 15 percent of the cases were rated as having had a mixed outcome; and 18 percent were considered to have had a poor or unknown outcome. The need for more objective measures to corroborate these perceptions was acknowledged (Alaska Department of Health and Social Services, 1991).

As noted, AYI developed a set of indicators to be used to measure the progress of individual youngsters. Based upon these data, the Alaska Department of Health and Social Services

(1989) reported that there were substantial increases in: the amount of time youngsters spent with their families, school attendance, parental involvement, and voluntary medication compliance. Sizable decreases were noted in: alcohol and drug possession, runaway episodes, assaultive behavior, property damage, contacts with the police, and suicide attempts.

Data from Vermont are available on the first 29 children to receive individualized care through therapeutic case management services (Santarcangelo, 1992). For these youngsters, who ranged in age from 8 to 19, reductions were found in the restrictiveness of their living environments. On a modified version of the Restrictiveness of Living Environments Scale (Hawkins, Almeida, Fabry, & Reitz, 1992), the level of restrictiveness was reduced from a mean score of 4.8 to 3.9 on a scale ranging from 1 to 9.8. The percentages of youngsters in various types of placements shifted as well, with shifts from 31 percent to zero in correctional or residential treatment settings and accompanying increases in placement in therapeutic foster care (17 percent to 35 percent) and in natural homes (3 percent to 10 percent). Trends from tracking the daily occurrence of troubled behavior suggest decreases in negative behaviors including: physical aggression, property damage, sexual assault, suicide attempts, and fire setting. While the results are encouraging, the small number of cases compromises the statistical significance of these data. Larger sample sizes will be achieved over time in Vermont and elsewhere and will, hopefully, lead to results with higher levels of confidence. Further, the many ongoing evaluations of individualized care across the nation should yield results in the near future.

V. MAJOR STRENGTHS AND CHALLENGES

Major Strengths

The strengths of individualized care are inherent in the underlying values of focusing on each individual child and family, providing services in the most normalized environment, working in close partnership with families, using a strengths-based, ecological orientation, providing culturally competent services, and offering unconditional care based upon a no-reject, no-eject philosophy. These values are congruent with, and partially derived from, the values for an overall system of care and represent a clear philosophy about the way in which services should be delivered to all children and families. In fact, a major strength of the individualized care approach is that its underlying values are consistent with the established values and principles for a system of care which have been widely accepted and adopted in many states and communities throughout the United States (Stroul & Friedman, 1986). Individualized services provide an opportunity to put the system of care philosophy directly into practice for youngsters and their families. In addition, a number of other strengths have made the use of this type of labor-intensive service approach advantageous to communities:

- o **Enhanced Outcomes** - The more broad-based, ecological assessments used in individualized service approaches lead to the development of intervention plans that have a greater chance of success. It is a reasonable assumption that treatment effectiveness will be enhanced when services are tailored to the unique needs of the child and family. In the long run, enhanced outcomes benefit not only the child and

family, but also will benefit the community which is more likely to regain the child and family as productive members.

- o **Consistency of Care** - The individualized care approach allows for supports to be provided not only to families but within all types of settings. This means that no matter where children and adolescents receive care (home, school or elsewhere), the likelihood for success is increased. When crises both large and small occur, extra services can be wrapped around both the youth and the service provider, offering the level of support needed to maintain the youngster in the community. Since most crises are short-lived, the need for more intensive support diminishes rapidly and the youth and care provider return to a more stable status quo. Where wraparound services are not available, even minor, short-term crises can cause a placement to fail and bring about the resultant use of a more restrictive placement. Individualized care approaches, with the flexibility to add services and supports as needed, allow multiple placements to be averted, saving restrictive settings for use by youngsters who truly need them. Thus, individualized services can help to keep youngsters within their own homes or within alternative home-like settings on a more consistent basis, minimizing placement in more restrictive settings.
- o **More Responsive Interagency Systems of Care** - The use of individualized services by communities for the most troubled and expensive children and adolescents has the potential for setting a tone for how services should be offered to everyone. As communities learn the advantages of the interagency coordination and collaboration that is required for this type of intervention, they hopefully can begin to understand the utility of a collaborative approach for meeting the needs of all children and adolescents and their families. While the commitment to meet the full range of individual needs of all children and adolescents who appear for services has the potential of adding a major strain on the capacity of service systems, the advantages in preventing troubling outcomes and more expensive future service needs may, over time, become obvious. Thus, the values, philosophy, and collaborative approach used to provide individualized care to the most challenging youngsters may begin to permeate the entire system of care, resulting in improved services for all youngsters and families.

Beyond the advantages to children and families from interagency coordination in communities, there also is a major advantage to the agencies which function with a new degree of cooperation. Most of the line workers in these agencies have clients with cross-agency needs. As they struggle to help children and families, these workers encounter significant barriers to obtaining needed services. Interagency structures created to deliver improved services for children and adolescents with severe emotional disturbance have, in a number of states and communities, grown to encompass services to all troubled children and families, spreading the benefits of interagency collaboration and the principles of individualized services to the entire community.

Major Challenges

In spite of the benefits that have resulted from the implementation of individualized service principles and processes, serious challenges exist to their general acceptance as well as to their application. Several of the major challenges are discussed below.

- o **Balance of Component Versus Individualized Services** - The development of community-based systems of care for children and adolescents with severe emotional disturbances and their families is now a broadly accepted national goal, and many communities are achieving progress toward the creation of such systems. A system of care must include an array of services as well as mechanisms for interagency coordination both at the system level and at the client level. This infrastructure for a system of care is critical as a community prepares to provide services which are community based, child centered, family focused, and coordinated. Within the context of a system of care, a remaining challenge is allocating resources between program components and flexible resources for nontraditional services and supports. Friedman (1983) wrote, "Given the importance of individualizing services, and the new developments that appear to take the individualized approach to a greater level than has traditionally been the case, what are the implications for a model of a system of care? First, it is important to recognize that the need for a wide range of services is still present. Second, however, the new developments suggest that there needs to be a balance within a system of care between the resources that go to specific programs and services and those that go specifically for the mechanisms that maximize individualization."

Friedman (1988) further noted that historically, most of the resources in the children's mental health field have gone toward the support of particular programs or services, or toward the purchase of slots in programs. Over the past decade, the range of program options has expanded, and resources have been used to fund new community-based service alternatives such as home-based services, crisis services, day treatment, and therapeutic foster care. However, funding for family support services such as respite care and other social services has been particularly difficult to obtain for this population. Likewise, the operational services described by Stroul and Friedman (1986) including case management, self-help and support groups, advocacy, transportation, and transitional services have been sorely lacking for children with serious emotional or mental disorders and their families. Flexible funding for wraparound services has been conspicuously absent in most systems of care.

In 1988, Friedman asserted that the next step in the evolution of systems of care may well be determining a better balance between funds that are flexible and those that are precommitted to existing programs or slots. However, this has not been an easy task. It has been suggested that the nature of the community (urban versus rural) may be a factor in determining the most appropriate mix of established programs and flexible funds for individualized care. In more highly populated areas, there may be sufficient demand for services to warrant the allocation of substantial resources for programs such as day treatment, home-based services, crisis services, therapeutic foster care, and other system components. In rural areas, where the demand may be insufficient to sustain a large number of programs, it may be appropriate to rely more

heavily on individualized services based upon flexible funding while maintaining a more minimal infrastructure of established service components. It is important to recognize, however, that individualized services have been successfully implemented in highly urban environments as well as in extremely rural and remote settings. Whatever the environment, determining an appropriate balance between component services and the mechanisms which support flexibility and responsiveness in individualizing services remains a major challenge to systems of care.

- o **Financing Individualized Services** - Creating viable mechanisms for financing individualized services is one of the major challenges for the future. VanDenBerg (in press) noted that budgeting procedures for flexible funding can be cumbersome and even prohibitive and that it is much easier, administratively, to provide grant funds for a residential program than to plan individually for each child. The Vermont New Directions Program (DeCarolis, 1992), in its Final Phase Proposal to the Robert Wood Johnson Foundation, identified the need for coordinated interagency policies to support a streamlined process for funding individualized wraparound approaches to service delivery as a major priority. The proposal states that: "In order to accommodate a flexible funding system within the rigid accounting practices of various departments and agencies, an extremely complex system has been developed to process individualized budgets and payments. While the present system works, it is extremely cumbersome and time-consuming for all involved, including business managers at the state and local levels of all agencies, therapeutic case managers, and New Directions Project staff. Issues such as cash flow problems and labor-intensive manual tracking of expenditures must also be resolved." Vermont has recently convened an interagency committee to develop recommendations for streamlining this process.

Thus, the challenge includes designing workable procedures for flexible funding that provide appropriate safeguards, fiscal management, and accountability procedures, but are not overly cumbersome for providers. Additionally, increasing the level of funds available for individualized care is essential as well as changing policies to increase incentives for providing individualized services to the most troubled youngsters in our systems of care.

- o **Limited Access to Individualized Care** - It is clear that having a range of services in place within the community can provide a supportive environmental context in which to implement individualized approaches. It also should be noted that the individualized approach has been very successful in a number of extremely rural areas with few formalized services available, such as Alaska, Idaho, and West Virginia. However, because of the labor intensity of this approach, it is unlikely that it could ever be made available to all of the children and youth with emotional or mental disorders who might benefit from it. To date, those states and communities implementing individualized services based on the philosophy and principles outlined above, have had to limit access to those youngsters who are the most seriously disturbed, who have the most complex functional problems, and who are usually in out-of-state residential care or at risk of being placed in residential care -- a subset of the total population of youngsters with severe emotional disturbances.

In fact, MacFarquhar and Dowrick (in press) report that of the 15 programs surveyed, the majority were serving fewer than 20 youngsters using an individualized assistance approach. The range of number of youth served was five to 165, with a median of six. While it is probable that these programs could serve greater numbers of youngsters if increased flexible dollars were to be made available, there is in all likelihood a point beyond which the programs would lose their ability to truly know each child and family in the intimate and collaborative manner that now operates among the pioneer programs.

- o **Training** - One of the largest remaining challenges to implementing individualized services is the challenge of reeducating and changing the attitudes of providers. This was first noted by Burchard & Clarke (1990) and confirmed by MacFarquhar & Dowrick (in press). For the most part, currently operating professional training programs, even at the finest universities, are steeped in extremely traditional approaches to mental health service delivery. Graduates have little or no exposure to innovative, community-based services, let alone a radical departure such as individualized services. A treatment philosophy of individualizing services for children and families, providing unconditional care, doing whatever it takes to support a child and family, treating families with respect, and treating families as partners in the process of developing a service plan is still foreign to many line workers. This philosophy has not been universally adopted by staff in child-serving agencies, nor has it been incorporated into the curriculum at most universities.

When asked the question, "What is the response of the providers in your community to a 'wraparound' approach versus the traditional component care?", over half the programs in MacFarquhar and Dowrick's study (in press) reported that providers were skeptical until they saw it actually work. Once they saw and experienced it, most providers became convinced and supportive of the individualized care approach. Olsen, Whitbeck, and Robinson (1991) reported that even when given permission and a vehicle to provide individualized care, providers often become "stuck" by limiting their thinking to program components; they suggest that changing the focus of the service system to the individualized approach requires a paradigm shift. MacFarquhar & Dowrick characterized the response of providers to the individualized approach as a developmental process: "Although many providers support the notion once they have seen it work, many still see funding attached to services and categories, a viewpoint that reflects a misunderstanding of one of the major tenets of an individualized assistance approach."

Thus, as is true with the whole range of new community-based services and service delivery approaches for children and adolescents with serious emotional or mental disorders and their families, an accompanying human resource development strategy needs to be developed for individualized care. This strategy must address the needs of a heretofore unserved population, and it must be prepared to address the needs of this population in all of the life domains. Recruitment and training of professional staff as well as aides and support personnel to provide individualized services require particular attention and may be both costly and time consuming. Further, staff support and quality control present additional challenges for the individualized care approach in which services are dispersed in the community. Mechanisms for

monitoring staff and clients must be built into the process of individualizing services to ensure the delivery of quality care.

The Future of Individualized Services in Systems of Care

In the past, service systems had limited ability to meet individual needs. As recently as 1982, Knitzer reported that only a handful of states were even beginning to meet their service responsibility toward children with mental health needs. Further, Knitzer found that if states were developing new services, they were focusing on traditional residential care rather than more cost-effective, community-based alternatives. Flexible funding was unheard of, and service programs often were bound by rigid eligibility criteria, which often excluded the most-in-need, and set formulas for delivering services to all youngsters. Youngsters who did not succeed within existing program models typically were rejected and/or referred on to yet another program. The advent of the system of care concept, explicated by Stroul and Friedman (1986), brought with it a new conceptualization of services for children. The system of care was presented not as a mere network of service, but rather as a philosophy about the way services should be delivered to troubled children and their families. The values and principles underlying the system of care emphasize child- and family-centered services, individualized services, services provided within the least restrictive environment, parent involvement in all phases of service delivery, cultural competence, interagency collaboration, and case management. Systems of care serving children and adolescents have developed significantly since 1986. Many of these evolving systems have been built on these values and principles, abandoning the less responsive, inflexible, institutionally based approaches of the past. One of the first comprehensive, community-based systems of care to be developed was in Ventura County, California, and much has been learned from the Ventura experience about building systems of care based upon this philosophy (Jordan & Hernandez, 1990).

The compatibility of individualized services with the state-of-the-art concept and philosophy of a system of care is apparent in two major trends. First, many states and communities have incorporated individualized service approaches into their systems of care, particularly for the most difficult-to-serve, at-risk youngsters. These approaches, while reserved for a relatively small percentage of the target population, are receiving increasing resources and attention. They are being used to return youngsters from out-of-state and in-state residential placements as well as to prevent such placements; evidence regarding the cost-effectiveness of individualized care approaches in meeting these goals is mounting.

Second, the principles and processes which characterize individualized services are increasingly being applied to service programs or "components" within systems of care. For example, VanDenBerg (1989) describes the modification of "categorical" programs in Fairbanks to allow for the provision of unconditional care and wraparound services. As a result of added flexible funds and some program modifications, existing service programs in Fairbanks have been able to provide individualized services and reduce their rate of referral for inpatient hospitalization to the lowest in the state. Another example of a component program which has a history of individualizing service interventions is home-based services. Home-based service programs, both short- and long-term models, provide highly flexible interventions which are tailored creatively to the needs of each client family. Most home-based programs are committed to doing whatever it takes to assist a child and family, and

many have flexible funds that can be used to purchase nontraditional services and supports (Stroul, 1988). Through the integration of individualized services principles and processes, the effectiveness of service programs is enhanced. Thus, the concept of individualized care, with its values and processes, is rapidly spreading throughout modern systems of care both in its "pure form" and as an enhancement or enrichment of existing component programs.

It is evident that individualized services and systems of care are mutually dependent at both conceptual and practical levels. Burchard and Clark (1990) noted that a complete system of care continues to be necessary to provide component services, but that an individualized approach can greatly enhance the system's cost-effectiveness. Similarly, Duchnowski and Friedman (1990) emphasized that modern systems of care should incorporate the philosophy and process of individualized services. They stated that within the context of a comprehensive system of care, "the flexibility and creativity to ensure that an individualized treatment program is developed for each youth and his or her family is now considered imperative."

The ultimate goal for systems of care is that all interventions, in whatever organization or programmatic form, be guided by the concept and values of individualized services. The process of assessing needs in an ecological, holistic manner, tailoring services to meet specific needs, involving families, using interagency strategies, and providing unconditional care should not be limited to the services provided to the most complex and challenging youngsters. Rather, this approach should permeate the entire system of care in a community -- a goal which is consistent with, and established by, the current system of care philosophy.

The high level of interest and rapid growth in individualized services is apparent in the results of the MacFarquhar and Dowrick survey (in press); more than half of the programs studied were initiated within the past three years revealing a significant trend toward increasing this type of approach nationally. One of the most difficult challenges to be faced by systems of care as they evolve throughout the 1990s may well be to achieve a viable balance between programmatic service components and individualized care approaches. Burchard and Clark (1990) suggest that the future of individualized care will be determined by further research and development. However, they note that the approaches developed to date have been encouraging and suggest vast potential to improve services and systems of care for troubled children and their families.

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Outpatient

Provided by Mental Health Center (MHC) and private contractors
Assessment; individual, group, and family counseling; psychiatric services

Home Based Services

Provided by contract with Sunrise Family Resource Center (Family Advocacy Program)
Short-term intensive family-based treatment, up to 6 months duration

Crisis Services

Provided by Mental Health Center
24-hour telephone and staff on call
Crisis bed

School Based Services

Schools contract with MHC for consultation to staff, preventative groups, and mental health evaluations for students

Preventive consultation provided in schools

by MHC funded through state contracts Home-School Coordinator jointly funded and supervised by MHC and Special Education to serve as case manager and liaison between home and school

Substance abuse program provided in schools
Substance Abuse Services

Provided by MHC Individual and group therapy, education program, 24-hour dry-out program

SAFE (Substance Abuse Family Education) provided jointly between MHC and Sunrise Family Resource Center provides intensive in-home services for 3 months

Therapeutic Foster Care

Provided by MHC 10 beds plus 1 crisis bed

Therapeutic Group Homes

Provided by private agencies 2 group homes for adolescents

Residential Treatment Services Bennington School in county and others out of county

Case Review Committee overseas all residential referrals

United Counseling Services of Bennington County
Ledge Hill Drive
P.O. Box 588
Bennington, VT 05201

Ralph Provenza, M.S.W.
Director of Specialized Children's Services
(802) 362-3950
(802) 442-5491

SERVICES, continued
Inpatient Services

Southwestern Vermont Medical Center will occasionally admit adolescents

Independent Living Services

Provided by Social and Rehabilitation Services through a transitional worker

Respite Services

Provided by MHC both in and out of home Parent Support Group

SYSTEM LEVEL COORDINATION
Local Interagency Team

Comprised of representatives of all agencies serving SED children within county, includes Parents

Meets monthly

Addresses system issues and policy, planning, resource distribution, problem-solving, and other major strategic issues across agencies to improve system of care Also focuses on ensuring that SED children get coordinated service plans and networking and brainstorming for difficult cases

Can refer cases to State Interagency Team if issues cannot be resolved at the local level

Case Review Committee

Comprised of representatives of Mental Health, Social and Rehabilitation Services, and Dept. of Education
Reviews and approves all residential treatment placements for individual children

Rural
18,000 Population
>1% Minority

CLIENT LEVEL COORDINATION
Intensive Case Management

Provided by MHC
1 case manager
Case load of 5/case manager
Coordinates treatment team meetings
Has access to flexible funding

Treatment Team Meetings

Organized by the case manager
Comprised of all providers involved with the youngster, parents, and child
Responsible for developing an individualized treatment plan and coordinating service delivery

FORT BRAGG, NORTH CAROLINA

Military Community

47,000 Population
64.5% White
27.1% African American
3.7% Hispanic
4.8% Other

Fort Bragg Demonstration Project
The Major General James H. Rumbaugh Child
and Adolescent Mental Health Clinic
351 Wagoner Drive, Suite 200
Fayetteville, NC 28303
Ted Lane, Ph.D., Program Director
(919) 864-8808

Intake Assessment

Provided by Mental Health Clinic (MHC)
Single portal to service system

Outpatient

Provided by MHC and partially contracted
to private providers

Individual, group, and family counseling;
psychological evaluations; psychiatric
services

Home Based Services

Provided by MHC

Duration of 8 to 10 weeks

Crisis Services

Provided by MHC

24-hour crisis hotline, face-to-face services,
and crisis bed

Day Treatment

Provided by MHC and contracted to private
providers

Omni School serves ages 11-18
Wagner School serves ages 11- 18
Cumberland Hospital provides partial
hospitalization for preadolescents

School Based Services

Provided by MHC on an individual basis as
needed

Wraparound services available

Substance Abuse

Provided by MHC

Specialized assessment, outpatient program
Integrated within all other services

Therapeutic Homes

Provided by MHC
38 beds available

Therapeutic Group Care

3 group homes provided by MHC
Additional beds by contract with private
providers

Residential Treatment Services

Cumberland Hospital Residential Treatment
Center

Inpatient Services

Cumberland Hospital
University of North Carolina at Chapel Hill
Duke University Hospital
Charter Northridge

SERVICES, continued

Therapeutic Camps

Contracted to private provider

Independent Living Services

In development

Respite Services

CLIENT LEVEL COORDINATION

Case Management

12 case managers

Case load under 20/case manager

SYSTEM LEVEL COORDINATION

Project Oversight Committee

Comprised of military and civilian agencies
Meets quarterly
Focuses on policy, planning, resource
distribution, and other major system and
strategic issues across agencies to
improve system of care
Reviews difficult cases to identify and
resolve interagency problems

Child Protection Team

Abuse and Neglect cases

Comprised of representatives of all key
child-serving agencies
Identifies gaps in system
Reviews difficult cases to identify and
resolve interagency problems

Chaired by Social Services

Meets monthly

Initial Staffing Conferences
Every child who enters system has initial
staffing conference to review intake
information for preliminary diagnosis,
treatment planning, and determining
appropriate level of care
Staffings conducted by multidisciplinary
team

Treatment Team Meeting

Comprised of representatives from all
involved agencies plus families to assess
clients and plan needed services and
resources for individual children
Team meets every 45 days or as needed to
adjust level of care

LEON COUNTY, FLORIDA

SERVICES

Assessment

Conducted by Community Mental Health Center (CMHC) and a range of private providers
Specialized assessments performed upon case-specific need

Outpatient

Provided by Community Mental Health Center (CMHC) and private providers
Individual, group, family, substance abuse, and specialized counseling

Day Treatment

Provided jointly by the CMHC and schools
Home Based Services
Multiple programs provided by CMHC, Child Welfare & Florida State University ICCP (Intensive Crisis Counseling Program) provides short-term crisis intervention for families at high risk for abuse and neglect.

Crisis Services

Provided by CMHC Emergency Services Unit
24-hour assessment, crisis intervention, and referral to community services

Crisis Residential Services

Provided by CMHC Project PATH (Positive Alternatives to Hospitalization) which admits some children

School Related Services

Special education continuum including SED center school for adolescents and school based programs for elementary age
CMHC provides on-site clinical services in schools to EH students and families
Substance Abuse Services
Provided by DISC Village
Comprehensive services including assessment, counseling, and residential treatment services for adolescents

Therapeutic Foster Care

Provided by CMHC and Father Flanigan's Boys Town
Therapeutic Group Care
Provided by Father Flanigan's Boys Town - 5 group homes

Multi-Agency Service Network for Severely Emotionally Disturbed Students (SED Network)

1950 N. Tennessee Street, Suite 10

Tallahassee, FL 32304

David Fairbanks, Project Manager
(904) 487-4319

SERVICES, continued

Individualized Wraparound Services
Provided by a variety of public and private providers
Customized therapeutic and support services

Residential Treatment Services

CMHC operates Wateroak residential treatment program
Contract with out-of-district providers for a limited number of children
Inpatient Services
Tallahassee Memorial Hospital provides short-term acute care for adolescents
Parent Group
Federation for Children's Mental Health

SYSTEM LEVEL COORDINATION

SED Network Interagency Council
Compromised of public & private agencies from Leon County and other 7 counties in SEDNET catchment area
Meets 2 to 4 times/year formally plus committees
Focuses on policy, planning, resource distribution and other major strategic issues across agencies to improve system of care
Annual Service Plan adopted resulting in cost-sharing agreements, multiagency contracts, and service development plan

SED Network Regional Planning Team
Comprised of mid-level managers, supervisors, and line staff of local agencies

Focuses on county-level service development and the functioning of the case management system

Small City
192,000 Population
24.2 % African American
2.2% Other

CLIENT LEVEL COORDINATION

Case Management
Case managers employed by SED Network and administered through community Family Service Planning Teams
3 full-time case managers
Caseloads 20-30/case manager

Family Service Planning Team
Standing team comprised of representatives of all child-serving agencies. Families plus all providers involved with a specific child attend meeting to develop individualized service plan for child and family
Wraparound monies available to team

CASE MANAGEMENT TEAMS

Organized by case manager
Includes all providers, schools, families, etc. involved with individual child to implement Family Service Plan and revise as necessary
Case Review Committee (CRC)
Multidisciplinary team that reviews all referrals for residential treatment and makes placement recommendations
All children must go through Family Service Planning Team process prior to referral to CRC for consideration for residential care
CRC also monitors placements and discharge planning
CRC has own case manager

NORFOLK, VIRGINIA

SERVICES

Outpatient
(CSB)

Individual, group, and family counseling; psychiatric services; substance abuse services

Family Services Unit of Juvenile Court
Services provides individual, group, and family counseling

Early Intervention
Provided by CSB, Norfolk Youth Network and public school system
Preschool Prevention, Infant Stimulation, Early Childhood Education Center serve young children at risk

Home Based Services
Norfolk Youth Network provides Home Based Program, 6-month duration for mental health population
Intensive Home Based Probation Program provided by Juvenile Court
Crisis Services

Provided by Mental Health Crisis Unit
24-hour telephone and staff on call

Crisis teams in schools

Day Treatment
Provided by South Eastern Cooperative Education Program and private providers

School Based Services
CSB provides student assistance counselors
Norfolk Youth Network provides alternative classroom for children returning from state learning centers
Norfolk Public Schools provide school-based consulting psychiatrist, anger management program, mentor program, and Parent Resource Center

Substance Abuse Services
Individual, group, and family counseling provided by CSB
Education and prevention programs provided by CSB and the Juvenile Court

Norfolk Youth Network
1600 East Little Creek Road, Suite 315
Norfolk, VA 23518
Lynn W. Moore, M.Ed., Coordinator
(804) 441-1857

SERVICES, continued

Therapeutic Foster Care
Provided by Norfolk Youth Network (Therapeutic Family Home Program), Social Services (Parent Teaching Homes), and contracts with private providers

Therapeutic Group Care
Provided by Dept. of Human Services

Two group homes for adolescents

Residential Treatment Services

Referrals to facilities primarily in-state

Inpatient Care

Short-term hospitalization in nearby community and state hospitals

Independent Living Services
Provided by Social Services and referrals to

Private "Connections" program

Therapeutic Respite Services
Provided by Norfolk Youth Network

SYSTEM LEVEL COORDINATION

Norfolk Youth Network
Interagency entity designed to serve multineed families and youth in city of Norfolk

Comprised of CSB, Public Schools, Public Health, Juvenile Court Services, Social Services, Juvenile Services Bureau
Network identifies needs, develops programs, and coordinates service delivery across agencies

Norfolk Interagency Consortium
Comprised of administrators of the 6 major child-serving agencies which are part of the Norfolk Youth Network
Meets twice/month
Focuses on system issues including funding, policy, and program development

Urban
261,229 Population
56.7% White
39.2% African American
2.9% Hispanic
4.8% Other

SYSTEM LEVEL COORDINATION, continued

Community Assessment Teams
Nine teams comprised of supervisory staff of the 6 participating agencies

Teams review and follow difficult cases
Teams make program development recommendations to Interagency Consortium

CLIENT LEVEL COORDINATION

Case Management
Case management provided within each child-serving agency

Lead case manager is assigned from the most logical provider agency by the Community Assessment Team

TREATMENT TEAM

Includes case manager, family, child, and all providers involved with the specific child and family
Develops and implements individualized treatment plan in a series of meetings

**NORTHUMBERLAND COUNTY,
PENNSYLVANIA**

SERVICES

Intake/Assessment/Case Management
Provided by Mental Health, Child Welfare,
and Juvenile Justice agencies within the

Dept. of Human Services
Outpatient

Provided by Northumberland County
Counseling services (NCCS)

Individual, group, and family counseling
Home Based Services

Short-term services provided by Children
and Youth agency (Family Preservation
Program)

Longer-term services provided by NCCS
(Homekeepers Program)

Crisis Services
24-hour telephone and staff on call

Outreach assessment

Short-term foster care
Day Treatment

Provided by Coordinated Learning
Alternatives for Northumberland County
Youth (CLANCY), regional special
education unit, and Geisinger Hospital

Youth Services
Provided by CLANCY

Life skills, GED, social rehabilitation, job
training, and job coaching
Substance Abuse Services

Provided by Drug and Alcohol agency and
private contract providers in community
Student Assistance Program in schools for
substance abuse and suicide prevention

Therapeutic Foster Care
Jointly administered by County Mental
Health and Child Welfare
15 bed "Host Home" program

Specialized foster care provided by Juvenile
Court

Therapeutic Group Homes and Residential
Treatment Services

Available outside county

Therapeutic Camp Services
Provided by CLANCY and Children &
Youth Services

NORTHUMBERLAND COUNTY HUMAN SERVICES

Human Services Building

370 Market Street

Sunbury, PA 17801

Jerry Wolfberg, O.D., Director of Human Services
(717) 988-4178

SERVICES, continued

Independent Living Services
Provided by CLANCY and Children &
Youth Services

Respite Services

Parent Center

Parent-run services jointly funded across all
systems

Serves a variety of parent populations to
provide parent support and education

Inpatient

Provided by Geisinger Hospital

SYSTEM LEVEL COORDINATION

HUMAN SERVICES MANAGERS MEETINGS

Comprised of administrators of all agencies
within umbrella Dept. of Human Services
Managers' briefings twice/month
Focuses on service integration issues,
planning, policy, and problem resolution

CASSP TEAM

Includes all agencies within umbrella
human service dept. plus education, other
provider agencies, families, etc.
Meets quarterly
Focuses on system development, progress,
functioning, and future planning

HUMAN SERVICES ADVISORY BOARD

Comprised of representatives of advisory
committees from each agency, parents,
education system, etc.
Meets monthly
Focuses on cross-system planning

96,771 Population
1.3% Minority
Primarily Hispanic

351

351

RICHLAND COUNTY, OHIO

SERVICES
Outpatient Services
Provided by The Center (CMHC)
Individual, group, and family counseling

Early Intervention

Birth to three years
Classes for youth and parents
Collaborative effort with a number of county agencies

Home Based Services
6 to 12 week intensive program
Collaborative Program of Mental Health and Children Services

Gateway
Central intake and case management
Jointly administered and funded by all agencies

Crisis Services
Provided by The Center
24-hour help line
Short-term foster homes
Staff available in emergency rooms

Day Treatment
Ages 10 to 14
Full day and extended day programs
Average 18 months duration
Jointly administered and funded by all agencies

School Based Services

Substance Abuse
Provided by The Center
Outpatient counseling, service coordination, and education

RICHLAND COUNTY Mental Health & Recovery

Services Board
30 Bowman Street
Mansfield, OH 44903 - 1698
William Wood, Executive Director
(419) 524-3345
Joseph Mudra, Cluster Coordinator
(419) 522-8213

Rural
126,000 Population
9% Minorities
8+% African American

SYSTEM LEVEL COORDINATION

Richland County Youth and Family Regional Council of Governments (COG)

Comprised of the executive directors of all key child-serving agencies
Meets monthly
Focuses on interagency issues, service priorities, planning, service development, and other administrative needs of system
Reviews difficult cases, not resolved by network meetings and other agency efforts
Administers Gateway and Day Treatment programs

Serves as Interagency Cluster
Voted to transform Cluster into a COG which can receive grants, hire staff, and provide services

CLIENT LEVEL COORDINATION

Case Management

Gateway has 3 case managers
15-20 families per case manager
Play "facilitative" role for children coming through Gateway
Assign staff of a service agency to assume lead case management role.

Network Meetings

Organized by Gateway case managers to develop system-wide service plan
Parents are full participants

250
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SAINT LOUIS, MISSOURI

Walbridge Caring Communities Program
5019 Alcott
St. Louis, MO 63120
Khatib Waheed, Program Director
(314) 261-8282

SERVICES

Outpatient Services

Provided by local mental health facilities including Hopewell CMHC, Hawthorne Children's Psychiatric Hospital, Bellefontain Psychiatric Hospital

Home Based Services
Provided by Families First, short-term intensive crisis intervention
2 in-home therapists with caseload of 2 families / therapist

Crisis Services
Provided by local mental health facilities and Families First home based services

Day Treatment
Provided by Caring Communities
Housed in Walbridge School for elementary children

School Based Services
Provided by Caring Communities
Youth Leadership Development Program provides recreation, cultural enrichment, and social competency development

After School Tutoring
Latch Key Program provides before and after school care, academic enrichment, and social competency skills

Substance Abuse Services
Caring Communities provides certified substance abuse counselor in school to work with children and families

Treatment provided through local facilities such as Black Alcohol/Drug Service Information Center (BASIC)

Anti Drug Task Force does community organizing to address drug abuse and drug trafficking

Queen of Peace residential treatment center

Therapeutic Group Care
Group homes provided by Juvenile Courts
Residential Treatment Services
Provided by facilities in St. Louis including New Beginnings, Providence Hospital

Urban
10,000 to 15,000 Population
90% African American

CLIENT LEVEL COORDINATION

SERVICES, continued

Inpatient Services	Provided by local facilities including Hawthorne and Bellefontain Independent Living Services provided by referral to Hope House transitional living program	Case Management Provided by Caring Communities 3 Case managers Case load of 15 families / case manager	Parent Conferences Comprised of staff from Families First, Case Management, Caring Communities site director as a standing team Attended by parents, teacher, and representatives of other involved agencies	Treatment Team Meetings Comprised of supervisors and service providers from the specific components involved with a child and family Purpose is to review cases periodically and to share information between components of Caring Communities regarding the individualized service plan
Respite Services	Provided by Caring Communities through overnight retreats	Walbridge Caring Communities Advisory Board Comprised of parents, teachers, and interagency team members	Addresses system-wide problems, concerns, service priorities, future planning, and service development Meets bimonthly	Inter Agency Team Comprised of representatives of the four state agencies which are the state-level partners in the development of Caring Communities: Mental Health, Education, Health, and Social Services Coordinates state agency resources and addresses service planning and development, overcoming obstacles at the state level, and restructuring services Meets bimonthly

SAN FRANCISCO, CALIFORNIA

SERVICES
Outpatient
Provided by contracts with a range of public and private providers
Developing a certified provider list
Assessment; individual, group, and family counseling; psychiatric services

Early Intervention
Provided by variety of resources within city such as Primary Intervention Project (PIP) which provides school based counseling and other services to at-risk children

Home Based Services
Provided by Family Mosaic
Developing long-term home based services, in-home family therapy, conflict resolution/mediation services, and short-term crisis-oriented family preservation

Crisis Services
Provided by city-wide Comprehensive Crisis Services and include 24-hour outreach, assessment, triage, and shelter beds

Day Treatment
Provided by Mental Health department, Social Services department and by contract to private providers

School Based Services
Provided by Primary Intervention Project
Family Mosaic may purchase school based services through certified provider pool
Children's outpatient services in mental health agencies provide school consultation
Substance Abuse Services

Family Mosaic purchases substance abuse services from city, county, or private providers including prevention; drug and alcohol rehabilitation; individual, group, and family counseling; and early intervention
Therapeutic Foster Care
Provided by DSS through contracts with private agencies such as Alternative Family Services

Therapeutic Group Care
Provided by DSS in and out of county
Residential Treatment Services
Family Mosaic purchases residential treatment services from certified provider pool which includes Adolescent Intensive Residential Services (AIRS) and Edgewood School

Urban
760,000 Population
21% Hispanic
16-18% Asian/Pacific Islander
14% African American

SYSTEM LEVEL COORDINATION, continued

SERVICES, continued

Inpatient

Family Mosaic purchases inpatient services from facilities including McAuley Inpatient Services, Ross Hospital for Adolescents, Langley Porter Psychiatric Institute Therapeutic Camps

Provided by Juvenile Justice (Log Cabin)

Independent Living Services

Provided by DSS through contracts with Private agencies
Respite Services

Family Mosaic contracts for respite care, primarily with Alternative Family Services
In and out-of-home respite available
DSS also provides respite services

SYSTEM LEVEL COORDINATION

Cluster Group

Comprised of department heads of all agencies serving SED children in county
Meets monthly
Addresses issues of policy, planning, resource distribution and other system and strategic issues across agencies to improve system of care

Interagency Advisory Council

Comprised of directors of major health and human service agencies serving children, community representatives, other provider groups, parents, and youth
Focuses on system level planning, coordination, and problem solving

CLIENT LEVEL COORDINATION

Specialized Case Management

Provided by Family Mosaic, Youth Advocates and San Francisco County Community Mental Health
Family Mosaic has 11 case managers
10-12 families/case manager
Combination therapeutic and brokerage case management approach

Plan of Care Meetings

Organized and facilitated by case manager
Involves children, parents, current agencies involved with families, current service providers, and potential service providers
Goal is to develop agreed-upon plan of care to be implemented by case manager

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STARK COUNTY, OHIO**SERVICES****Outpatient Services**

Provided by the Child and Adolescent Service Center (CASC)

Assessment

Individual, group, and family counseling
Psychiatric services

Prevention and Early Intervention

Provided by the CASC and the Early Intervention Collaborative
CASC Provides mental health component to Head Start

Home Based Services

Short-term program provided by Crisis Intervention Center (TIES)
12 weeks, placement prevention focus
Long-term program provided by CASC
Average duration 1 year, family reunification focus

Day Treatment

Joint program of the CASC, Canton City Schools, and Dept. of Human Services (DHS)

School-Age Day Treatment

Average 18 months duration

Crisis Services

Provided by the Crisis Center
24-hour hotline
Walk-in services

Mobile outreach crisis services

Four observation beds at Crisis Center
Child and Family Advocacy Program

Provided by the CASC
Assessment and treatment of child sexual abuse

Substance Abuse Services

Provided by Quest Recovery Services
Intensive outpatient treatment program
Youth Sex Offenders Program
Joint program of the CASC and Family Court

Therapeutic Foster Care
Provided by contract with private agency (Pathways)

Therapeutic Group Care
Provided by DHS group homes

Stark County Mental Health Board
800 Mark Avenue North, Suite 1150
Canton, OH 44702
Beth Dague, M.A., Children's Coordinator
(216) 455-6644

Small City
367,585 Population
8.3% Minorities
7.5% African American
>1% Hispanic

SERVICES, continued**CLIENT LEVEL COORDINATION**

Mental Health Case Managers
Provided by the CASC
13 case managers, 2 supervisors
Caseloads 15-20/case manager
Priority for youngsters in, returning, or at risk for hospitalization

Residential Treatment Services
Provided by a number of out-of-county facilities including Parmadale, Berea, Smithville Boys Village
Inpatient Services
Provided by Timken Men-y, Aultman, and Akron Children's Hospitals
Respite Services
Provided by Tri-County Easter Seals

SYSTEM LEVEL COORDINATION

Creative Community Options (CCO) Meetings
Include representative of all involved agencies to assess strengths and needs and develop comprehensive service plan
Parents and child are full participants

Stark County Interagency Children's Cluster
Comprised of the executive directors of all key child-serving agencies
Meets monthly
Focuses on interagency issues, service priorities, planning, service development, and other administrative needs of system
Reviews difficult cases not resolved by CCO process and ACCORD
Developed interagency agreement regarding interagency funding of multineed children and families

ACCORD
Standing group of mid-level managers from multiple agencies
Try to reach consensus on service delivery and funding problems that could not be resolved during service planning process
Cases which cannot be resolved at ACCORD level can be presented to Cluster

**VANCE, WARREN, GRANVILLE &
FRANKLIN COUNTIES, NORTH CAROLINA**

SERVICES

Outpatient
Provided by Area Mental Health (MH) at 4 clinics
Individual, group, and family counseling

Home Based Services
Family Preservation Program provided by MH which offers crisis intervention, 4-6 week duration, 20 hours/week
Entry by interagency screen team
Youth and Family Alternatives provides home based services for adjudicated youngsters referred by court system, duration up to 16 weeks

Day Treatment
Provided by MH in collaboration with 5 school systems for children ages 7 - 18
Full day, year-round program at one site
Recreational After School Program (RAP)
Socialization and prevocational services 3 hours/day, year-round

Therapeutic Preschool
Provided by MH
Serves children ages 3 - 6 and families
Crisis Nursery Program
Serves children birth - age 4
Provides in-home, respite, and center-based services

Therapeutic Foster Care
Provided by MH
9 active homes
Entry by interagency screening team

High Management Group Home
Provided by MH
5 beds for adolescent males
Integrated with day treatment
Entry by interagency screening team
Residential Treatment
Occasionally use Whitaker School and Wright School (both re-ed models)

Inpatient
Acute care and long-term adolescent unit provided by John Umstead State Hospital
Local regional hospital with adult psychiatric unit will admit adolescents with supervision from Area MH

Area Mental Health, Developmental Disabilities

& Substance Abuse Programs for Vance, Warren, Granville & Franklin Counties

Community Mental Health
125 Emergency Road

Henderson, N.C. 27536
Peter Horner, Director of Child & Family Services
(919) 492-4011

SERVICES, continued

CLIENT LEVEL COORDINATION

Respite Care

Respite in family based homes for 1-14 day duration provided by MH
Planned or emergency use
8-10 homes available for respite care
Big Brother/ Big Sister
Provided by MH for ED and delinquent youngsters

Recruit and train specialized volunteers to work with youngsters

Adolescent Parenting Program

Joint program between MH and DSS
In-home and other services to teen parents
Court Psychologist Program
Provided by MH
Assessment, treatment recommendations, consultation for court referrals

SYSTEM LEVEL COORDINATION

Interagency Task Forces

Task Forces organized in each county
Meet monthly
Focus on interagency issues, service priorities, planning, service development, coordination, and other strategic issues to improve system of care
Some Task Forces make recommendations regarding the use of "Community-Based Alternatives" funds which are targeted toward delinquent and predelinquent youngsters

Rural
133,664 Population
38% African American
2% Native American

VENTURA, CALIFORNIA**SERVICES**

Outpatient Options Program provided by Mental Health Dept. (MH)
Intensive individual, group, and family counseling

Forensic Adolescent Program provides specialized outpatient services to juvenile sex offenders

Early Intervention Primary Intervention Program School based (grades K through 3)

Home Based Services Project Genesis provided by Interface under contract to MH

Short-term crisis approach Duration 4 to 6 weeks, 12-15 hours/week

Crisis Services and Respite Provided by Options Program, Genesis, Case Management, Clifton Tabum Center (Juvenile Justice)

Shomair Shelter Care, a joint service of MH and Child Welfare, provides crisis foster care Crisis home with 6 beds

Day Treatment Phoenix Program, a joint program of MH and Special Education, provides a psychoeducational program for elementary and high school youngsters

Enriched Special Day Class provided by MH, Special Education, and regular education

Visions Interagency Program provides day treatment for juvenile offenders Therapeutic Foster Care Shomair Enriched Foster Care

Mental health staff support is provided to foster parents Residential Treatment

Colston Youth Center - 45-bed maximum security facility, joint program of MH, Special Education, and Juvenile Justice Santa Rosa Treatment Home provides intensive care, 4 beds Group homes in and out of county

Ventura County Mental Health
300 Hillmont Avenue
Ventura, CA 93003
Mario Hernandez, Ph.D., Chief
Children and Youth Services
(805) 652-6737

SERVICES, continued

Inpatient Contracted beds (2) in private psychiatric hospital in adult inpatient unit

Camarillo State Hospital (6 beds)
Specialized Services

Community-Based Residential Alternatives provide flexible funds for supervision, recreation Resource Development Project provides donated goods and services matched to youngsters' needs

SYSTEM LEVEL COORDINATION

Interagency Juvenile Justice Council Comprised of executive directors of all key child-serving agencies, members of Board of Supervisors

Chaired by Juvenile Court Judge Focuses on interagency issues, policies, planning, financing Meets regularly

Interagency Case Management Council Comprised of middle managers and the Coordinator of Case Management Examines difficult cases and interagency problems in service delivery

Agency Screening and Placement Committees Review Process for Juvenile Justice and Child Welfare Involves Mental Health staff and Case Managers

Reviews difficult cases of youth being considered for more restrictive placements

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